Government of the Northwest Territories
Department of Health & Social Services

Performance Measurement and Accountability Framework

Accountability Report

Final – April 2014

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1.0 Introduction

1.1 Project Background and Rationale

Nationally, health care expenditures are increasing at a rate that is not considered sustainable. In order to ensure the sustainability of a publicly-funded system through innovative system reform, ***improving the accountability within the system is critical.*** There is an increasing interest across Canada in moving towards consistent, pan-Canadian indicators to monitor and report on health and social services system performance and outcomes. Multiple organizations, associations and scholars have published articles and opinion on Canada"s health and social service system accountability needs. There has been significantly more work done in regard to development of pan-Canadian health indicators than there has been in regard to Child Welfare. Three examples of work that has been done in these two sectors include.

- In 2011, the Canadian Nurses Association in a pre-budget brief to the House of Commons Standing Committee on Finance stressed the need for a comprehensive set of pan-Canadian health system indicators that demonstrate quality improvement across the continuum of care[1].

- In their report, Enhancing Pan-Canadian Health System Performance Reporting, the Canadian Institute for Health Information (CIHI) identify that "many countries are now regularly releasing public reports on the performance of their health system, with an increasing emphasis on measuring outcomes and value for money." This same report highlights that different audiences are interested in different aspects of health system performance. A hospital may require detailed information about surgical programs and care processes, while a policy maker is most interested in system trends, and users of the health and social services system want to understand if they are receiving good care relative to the expense of providing it.

- The National Child Welfare Outcomes Indicator Matrix (NOM) was developed by the provincial and territorial Directors of Child Welfare and Human Resources Development Canada[2]. It provides a framework for tracking outcomes for children and families receiving child welfare services that can be used as a common set of indicators across jurisdictions.

In order to measure the performance of a health and social services system there must be an ability to assess and compare performance. This assessment and comparison of performance is commonly referred to as benchmarking. Benchmarking is an analytical tool that helps determine where a system currently stands so that the system can explore why and how it can get to where it wants to be. Benchmarking is not an end unto itself, but rather a tool that highlights strengths and weaknesses, so that the system can determine what level of performance is possible, and explore how to make changes that promote improvement[3].

It is within this national context that the Northwest Territories (NWT) like other Canadian jurisdictions is actively seeking to enhance accountability with their health and social services system. The NWT health and social services budget now makes up more than 25% of the overall Government of the Northwest Territories (GNWT) annual budget and has increased at a rate greater than health care transfers. In

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[1] Canadian Nurses Association. (2011). Canada"s Health Accountability Plan. Pre-Budget Brief to the House of Commons Standing Committee on Finance. Retrieved from *www.cna-aiic.ca/.../pre-budget_brief_canada_health_accountability_plan*

[2] Trocme, Nutter, MacLaurin and Fallon, 1999), Child Welfare Outcome Indicator Matrix, Toronto, ON: University of Toronto: Bell Canada Child Welfare Research Unit, http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.pdf

[3] The Conference Board of Canada. Report 2012. Measuring Success: A Framework for Benchmarking Health Care System Performance.

addition, the cost per capita of providing access to health care is higher in the NWT than most Canadian jurisdictions. The rising costs of health care is driving the need to implement innovative reform across the NWT health and social services system and to improve overall accountability and performance monitoring in the system.

In 2010, the Office of the Auditor General undertook a program and services review of the NWT Health and Social Services (HSS) system. Among the recommendations coming out of that review was that the Department of Health and Social Services (DHSS):

- Develop a set of system-wide performance indicators;
- Develop a program evaluation plan, setting out areas it plans to evaluate; and
- Regularly inform the Legislative Assembly about the performance of the NWT health care system.

Further, the DHSS" Strategic Plan, *Building on our Foundation 2011-2016*, includes commitments to enhance the ability of the NWT HSS system to monitor and report on outcomes. This project is moving forward concurrently with other key initiatives, notably consideration of the potential to reform the NWT system"s governance structure and exploration of the potential to implement „back office" consolidated and collaborative services for the system.

1.2 Project Scope and Approach

The DHSS engaged MNP to assist with:

- The development of an inventory of existing performance monitoring and reporting within the system, and working with primary stakeholders to identify system-wide performance and reporting requirements; and
- The development of an overall accountability framework that outlines performance reporting requirements for key target audiences, including timing, indicators, and data collection responsibilities, and creation of an action plan to implement the accountability framework and performance measurement system.

The desired outcome from this project is: *Clear and appropriate accountabilities and reporting functions within the NWT Health and Social Services System to ensure that credible and timely information on the ongoing relevance and performance of all HSS program spending is available and is used to support evidence-based decision-making with respect to policy development, expenditure management and program quality assurance.*

MNP completed project work in two Phases:

- **Phase 1: Review and Assessment – Inventory & Reporting Requirements.** The work in this phase included:
  - Collecting and reviewing existing documentation and administrative data sets.
  - Reviewing of legislated reporting requirements.
  - Conducting interviews with DHSS representatives, Health and Social Service Authority (HSSA) representatives, and other identified stakeholders.
  - Conducting other jurisdiction and leading practice research.
  - Developing the gap analysis report.
- **Phase 2: Update Accountability Report.** The work in this phase included:
  - Working session with the Accountability Steering Committee.
  - Detailed analysis and development of draft Accountability Framework.
  - Validation session with the Accountability Steering Committee.
  - Development and presentation of final Accountability Framework.

An Accountability Steering Committee (Committee) was established to guide the work of the project and provide feedback to MNP and the NWT Project Manager. The Committee included:

- DHSS Deputy Minister;
- Representatives from four Health and Social Service Authorities;
- DHSS Chief Information Officer;
- DHSS Director of Community Wellness and Social Services;
- DHSS Director, Population Health;
- STHAs Medical Director;
- DHSS Director of Corporate Planning, Reporting and Evaluation; and
- DHSS Chief Medical Officer of Health.

The Committee"s involvement in selecting performance indicators is detailed in Section 7.2 Performance Framework Development Approach.

Phase 1 Consultations

Key stakeholder interviews were completed to inform the work. Specifically during phase 1, key informants provided input regarding:

- What information is currently collected
- What information is believed to be useful
- The challenges with collecting the required information and data
- Suggestions for improvements to the collection and reporting process
- Understanding of the legislative requirements for reporting
- Understanding of future reporting requirements

Individuals consulted included:

- Seven representatives from the DHSS
- CEO"s from each HSSA
- Four quality assurance and risk management coordinators

Phase 2 Consultations

In the spring of 2013 it was determined that additional consultation was required to more fully explore and understand the current capacity of the DHSS to collect, consolidate and report on the measures that were being considered for inclusion in an accountability framework, as well as the technology available to DHSS to capture this information. To develop this understanding a second set of consultations were completed and included representatives from:

- Public Health
- Health Services Administration
- Information Technology
- Territorial Health Services
- Human Resources
- Finance

The opinion of three Aboriginal Government representatives was also sought to gain insight into the needs of Aboriginal government and communities in regard to system performance measurement.

Unfortunately, only one of these interviews was completed due to scheduling conflicts of the Aboriginal representatives.

1.3 Purpose of Accountability Report

This report was developed as an internal document to be used by the DHSS to guide the implementation of a new accountability framework and performance measurement framework for the health and social services system. The intention is to provide the DHSS with an understanding of the current state of accountability and performance measurement for the NWT HSS system, compare that to what the NWT HSS system accountability framework and performance measurement could be in the future, identify the gaps that exist between the current state and potential future state, and finally to propose a new performance measurement framework and associated accountability framework components.

1.3.1 Report Structure

This report documents the work completed for Phases I and II of this project and includes:

- **Phase I (Section 2.0 – 6.0 and Appendices A and B)**
  - Definitions of accountabilities and descriptions of types of performance measurement indicators.
  - A description of NWT HSS accountabilities based on the current accountability framework.
  - An inventory of the current reporting for DHSS and HSSAs (Appendices A and B).
  - An assessment of the current capacity within the NWT HSS system to collect data and monitor performance.
  - A description of health and social services system accountability and performance measurement practices in Alberta, Saskatchewan and Nova Scotia.
  - A description of leading practice for health system accountability and performance measurement.
  - An opinion and description of the critical success factors for a new NWT HSS system accountability framework.
  - An opinion regarding gaps in the current accountability framework.
- **Phase II (Sections 7.0 – 8.0 and Appendices D, E and G)**
  - Recommendations: Accountability framework (Section 7.0 and Appendix D)
  - Recommendations: Performance framework (Section 8.0 and Appendices E and G)

2.0 Accountability Definitions

Accountability is a popular term and concept that is often ill-defined and misunderstood. The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions (Brinkerhoff 2003). There are two aspects to answerability including an informing aspect or transparency to report the activities and outputs of what was done and a justification aspect to provide reasons to explain the why behind the activities and outputs.

In healthcare, being accountable has been defined as taking responsibility for activity and decisions and "accountability implies the promise of responsible and responsive governance, which includes ethical behavior and the ability to stimulate desired performance through control and oversight" (Health Council of Canada 2012). In 2012, the Commission to Promote Sustainable Child Welfare Report: A New Approach to Accountability and System Management, acknowledged the Health Council of Canada"s definitions of accountability indicating, "we find that the Council"s definitions provide a helpful clarification, that brings together the focus on stewardship and control....our understanding is that accountability includes both stewardship and improvement and that both senses of the term are entirely compatible, and should be expected to be a responsibility for all institutional instances within the Child Welfare system..."[4].

However, accountability in the Canadian health and social services context is challenging as it is not always clear as to who is being held accountable, to whom, for what and to what end.

The current Accountability Framework for the NWT HSS system defines accountability as the obligation to report on the actions taken to fulfill one"s assigned responsibilities. Accountability is fundamental to establishing effective relationships and to good management practices.

In order for accountability to be effective, there needs to be clearly defined responsibilities and performance targets, accurate and timely reporting of performance measures, and the power and authority for an overseeing actor to impose consequences for achieving or not achieving performance targets (Health Council of Canada 2012). Accountability with no sanctions is typically considered to be weak accountability (Brinkerhoff 2003).

2.1 Other Terms and Definitions

A number of other terms and concepts are indentified in the Health Council of Canada 2012 report that MNP believes is relevant to the NWT HSS including:[5]

- **Transparency** - the open sharing of information on health care. Transparent reporting of goals, health indicator results, and performance is considered by some to be essential for driving quality improvement, and should be the foundation of quality-focused health care systems.
- **Performance Measurement** - the extent to which the delivery of health care services or health system activity achieves specific standards, benchmarks, or targets.
- **Health Indicators** - summary measures of health and the factors that affect health. Given the appropriate context, health indicators can provide a basis for comparison and performance measurement.
- **Benchmarks** - standards or reference points against which health indicators are measured and compared.

[4] Commission to Promote Sustainable Child Welfare. A New Approach to Accountability and System Management: Report and Recommendations. September 2012.
[5] As defined in the 2012 Health Council of Canada Report

2.2 Indicator Definitions and Fundamentals[6]

Indicators provide critical information on performance, achievement and accountability, which is the cornerstone of effective monitoring and evaluation. In addition, the data from indicators provide the strategic insights that are essential for the effective management of a health system. To be valuable, indicators need to be of high quality and able to collect the right data in the right place at the right time.

2.2.1 What is an Indicator

Fundamentally, an indicator provides a sign or a signal that something exists or is true. It is used to show the presence or state of a situation or condition. In the context of monitoring and evaluation, an indicator is a quantitative metric that provides information to monitor performance, measure achievement and determine accountability. It is important to note that a quantitative metric can be used to provide data on the quality of an activity, project or program.

A good indicator should be clear and concise. It should focus on a single issue that provides relevant information on a situation; particularly information that provides the strategic insight required for effective planning and sound decision-making. Good indicators are also defined by the feasibility of collecting meaningful and credible data for them. In addition, good indicators should actually and accurately measure what they claim to measure. If it is not feasible to collect data for an indicator, or the data that can be collected are not meaningful, the indicator will have little or no utility. Any indicator is only as valuable as the quality of the data it uses and it is crucial that the data are valid, reliable and not biased.

An important but often-overlooked fact about indicators is that they merely indicate. They do not capture or convey the many dimensions of a given situation and/or activity. They are directional such that they provide basic information on the past, present and possible future course of an activity, program and/or behaviour. They are also very context-specific such that higher values or lower values can be either good or bad, depending on the situation. The desired direction of the indicator (i.e. an increase or decrease) is usually determined when the indicator is selected and before data collection begins.

Indicators are not designed to replace more detailed investigations of specific issues, nor should they be used to do so. Consequently, information generated by indicators should always be interpreted within the broader context of the situation and supplemented where necessary by special studies, other evaluation activities and other types of data. Indicators are an essential part of effective monitoring and evaluation. They can provide vital information on performance, achievement and accountability. However, indicators are only one part of a comprehensive accountability framework. They are only one method for collecting and analyzing data and it is imperative that they be used when and where they provide meaningful information and insight.

2.2.2 Essential Components of an Indicator

The following are critical components of an indicator:

- The indicator has a clearly stated title and definition.
- The indicator has a clearly stated purpose and rationale.
- The method of measurement for the indicator is clearly defined.
- The data collection methodology and data collection tools for the indicator data are clearly stated.
- The data collection frequency is clearly defined.
- Any relevant subgroups that collected data can be separated into in order to more precisely understand and analyze the findings are clearly defined.

[6] Based on An Introduction to Indicators. UNAIDS Monitoring and Evaluation Fundamental Series, January 2010.

- There are guidelines to interpret and use data from this indicator.
- The strengths and weaknesses of the indicator and the challenges in it use are identified.
- Relevant sources of additional information on the indicator are cited.

Indicators should always have a proven track record (i.e. demonstrated performance in field-testing or operational use) before they are broadly deployed. It is impossible to underestimate the value of a proven track record. Most importantly, it prevents the allocation of resources on indicators that cannot or will not provide useful data.

2.2.3 What Makes a Good Indicator

Good indicators are:

- **Action focused.** Indicators should lead to action. If stakeholders cannot imagine what to do with the data from an indicator, then it probably isn't a good indicator.
- **Important.** Stakeholders should agree that the indicator and the data it will generate make a relevant and significant contribution to determining how to effectively respond to the outcome.
- **Measurable.** Not only must the data collection methodology be defined, it must also be feasible to collect the data.
- **Simple.** There are very few indicators if any that are perfect. Rather than pursue the perfect indicator, it is much better to identify good, simple indicators that provide data that can be put to use.

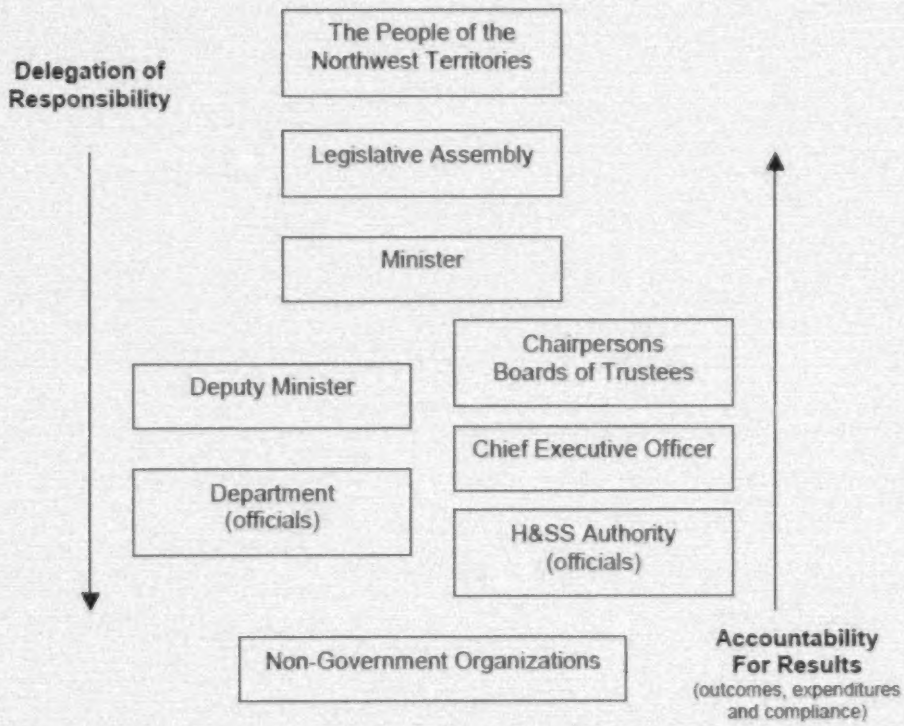
3.0 Current State – What is Now

3.1 Accountabilities – Current Accountability Framework

The current Accountability Framework for the NWT HSS system was developed in 2003. The following section summarizes the key aspects of the current framework.

The current framework makes an important distinction between responsibility and accountability. Responsibility confers an obligation to take action and accountability confers an obligation to report. The delegation of responsibilities and the associated accountabilities for the NWT HSS system under the current framework are articulated in Figure 1.

Figure 1: Outline of Delegated Responsibility and Accountability for Results under Current Framework[7]



The accountability for health and social services extends beyond the boundaries of the NWT. The authority for the Legislative Assembly to deliver health and social services derives from the *Northwest Territories Act* and the *Canada Health Act*, both of which are the responsibility of the Parliament of Canada. Therefore, there is accountability to the Government of Canada.

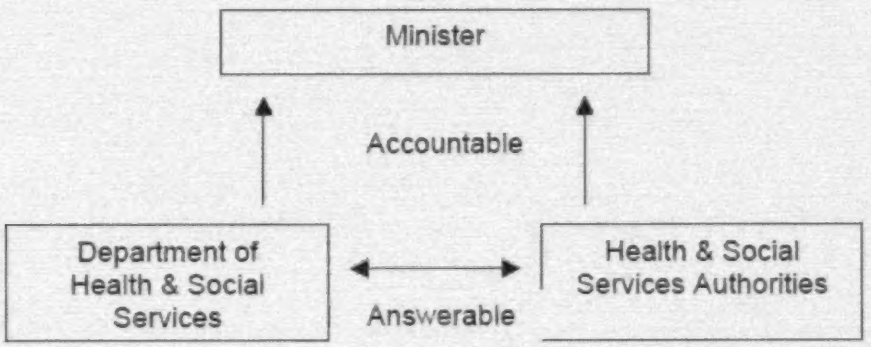
In addition to being accountable to the Government of Canada, the Legislative Assembly is also accountable to the people of the NWT who elect them.

[7] As per graphic included in the 2003 NWT HSS System Accountability Framework.

The Minister of HSS is delegated the responsibility for the delivery of health and services from the Legislative Assembly and is accountable to them (Figure 1). The process of delegating responsibility for health and social services continues on to the Deputy Minister and the Trustees of the HSSAs. The Deputy Minister in turn delegates responsibility to DHSS officials and the HSSA Trustees delegate responsibility to HSSA Executive Officers and officials. Responsibility is also delegated from DHSS and HSSA officials to non-government officials. Each time that responsibility is delegated from one level of the system to another, an obligation to be accountable is created.

Under the current framework, the DHSS and the HSSAs are both accountable to the Minister of HSS, but are also answerable to each other (Figure 2). Answerability is also present within the Joint Leadership Council (JLC) and the Joint Senior Management Committee (JSMC).

Figure 2: Relationship between Minister, DHSS and HSSAs in Current Framework



In addition to outlining how responsibility is delegated within the NWT HSS system, and the associated accountabilities, the current framework also describes the roles and responsibilities amongst partners in the system. The current reporting obligations within the NWT HSS system are summarized in Section 3.2 and detailed in Appendices A and B.

3.1.1 Contribution Agreements with HSSAs

There are annual contribution agreements between the GNWT (as represented by the Minister of HSS) and each HSSA. The contribution agreements document the amount of funding contributed by the GNWT to the HSSA, a budget with how the funds are to be spent to deliver Core Services to NWT residents, funding restrictions, a payment schedule for the funding, the reporting requirements, and insurance requirements.

3.1.2 Contribution Agreement Reporting Requirements

The contribution agreements require that each HSSA submit a number of financial reports including quarterly variance reports, a year end variance report, audited financial statements and an annual budget submission. In 2012 these agreements were modified in response to the 2012 Report from the Auditor General and HSSAs are also required to report: the number of emergency visits (by Canadian Acuity Triage Scale); and the number of scheduled appointments, no shows and visits to family physicians and nurse practitioners.

3.2 Current Reporting

This section provides an overview of the current reporting in the NWT HSS system. Current reporting as outlined through legislation as well as non-legislated reporting was identified by having DHSS representatives update the reporting obligations identified in the 2007 Sierra Systems worksheet from the Data Warehouse Preliminary Analysis Project. Currently, the DHSS lists 66 reports based on the rational identified by each division. A complete inventory of the reporting is provided in Appendices A and B.

Legislated reporting requirements are as follows:

Medical Care Act

- Under the Medical Care Act, the Minister of Health and Social Services is obligated to table a report on the operations of the Medical Care Plan. The Department also meets the reporting requirements under the Medical Care Act through the annual reports.

Child and Family Services Act

- Director of Child and Family Services is required to prepare and submit an annual report to the Minister. The last CFS report was provided to the Minister in 2004, and covered information for the 2001/02 fiscal year.

Mental Health Act

- No annual reporting requirements to the Minister. However, medical practitioners are required under specific circumstances to provide reports to the Minister (such as when a medical practitioner orders the detention of a person).

Dental Mechanics Act; Optometry Act; Veterinary Profession Act; Dental Profession Act

- Boards of Inquiry or Review Officer are required to submit a report to the minister on every complaint they investigate.

Nursing Profession Act

- President must present report to Board of Directors at least once every two years
- Treasurer must present statement of financial position at least once every two years

Tobacco Control Act

- Inspector must submit report to Minister of any seizure of tobacco under the Act.

3.3 Current Performance Measurement

This section provides an inventory of the current performance measures tracked and reported by the DHSS and the HSSAs. The performance measures historically reported by the HSSAs are distinct from the performance measures tracked and reported by the DHSS.

3.3.1 NWT Health and Social Services System

The NWT HSS system has documented performance measures in the 2011–2016 Strategic Plan, the 2011/2012 Annual Report, and the Quarterly Performance Measures Report. An inventory of the performance measurement indicators included in each report is provided below (Table 1).

Table 1: Inventory of Performance Measurement Indicators for the NWT HSS System

Performance Measurement Indicator	2011-2016 Strategic Plan	2011/2012 Annual Report	Quarterly Performance Measurement Report (Spring 2012)
Percentage of no shows for Medical Travel	✓	✓	
Percentage of no shows for specialists	✓	✓	✓
Percentage of no shows for family practitioners and nurse practitioners	✓	✓	✓
Data collected and outcome measures reported on	✓	✓	
No show rate by specialty and location			✓
No show/cancellation rate for elective surgery, overall and by reason			✓
Percentage of children receiving services in their home community	✓	✓	
Percentage of children receiving services in their home or w/ a relative	✓	✓	
Number of communities w/ a CFS committee	✓	✓	
Number of Foster Care Families	✓	✓	
Number of communities where respite is available	✓	✓	
Number of communities w/ a Healthy Family Program	✓	✓	
Self-reported health status - % of NWT pop reporting health as excellent or very good	✓	✓	
Ambulatory care sensitive conditions as proportion of overall hospitalizations	✓	✓	
Rate of hospitalization where a mental health issue was the primary reason	✓	✓	
STI incidence rate (Chlamydia, Gonorrhea, and Syphilis)	✓	✓	
Number of smokers who report being counseled to quit smoking by their primary care provider	✓	✓	
Incidence rate of Diabetes in the population age 45 to 59 years	✓	✓	
Low limb amputation hospitalization rate among people w/ diabetes, age 40 & up	✓	✓	✓
Percentage of obese adults	✓	✓	
Prevalence of smoking (age 15&up)	✓	✓	
Prevalence of heavy (binge?) drinking (age 15 to 24)	✓	✓	
Reduced hospitalizations due to injury (Injury Hospitalization Rate)	✓	✓	
Percent of clients receiving home care in their community	✓		
Number of clients receiving home care in their communities		✓	
Incidence of active TB	✓	✓	
Number of clinical telehealth clients	✓	✓	

Performance Measurement Indicator	2011-2016 Strategic Plan	2011/2012 Annual Report	Quarterly Performance Measurement Report (Spring 2012)
Incidence of community acquired of MRSA	✓	✓	
Percentage of residents satisfied w/ overall health services	✓	✓	
Degree to which mental health and addictions services meets the needs of clients	✓	✓	
Number of Telehealth Clients, overall and by session type			✓
New child welfare cases - ratio of non-court to court involved			✓
Average number of placements per year, per child.			✓
Proportion of children by number of placements of per year			✓
Children receiving services - proportion non-court involved in system			✓
Long-Term Care Facility Occupancy rate			✓
Number of clients on Territorial Admissions Committee Waitlist			✓
Territorial Admissions Committee Clients by Placement Location			✓
Proportion of Emergency Visits Non-Urgent			✓
Proportion of Emergency Visits by level of Urgency			✓
MRSA Incidence rate			✓
STI incidence rate			✓
Population hospitalized for a mental health issue (# per 1,000)			✓
Number and rate of mental health hospitalizations (primary diagnosis)			✓
Proportion of mental health hospitalizations by type of primary diagnosis			✓
Proportion of hospitalizations for alcohol and drug related issues			✓
Hospitalizations for A&D related issues by substance type			✓
Hospitalizations for A&D related issues by clinical state			✓
Hospitalizations for A&D related issues by secondary issue			✓
Secondary Health Issues of A&D Hospitalizations (#, %)			✓
Number of Out of Territory A&D Treatment Referrals			✓
Population Hospitalized for Self-inflicted injuries (#, # per 1,000)			✓
ACSC as a proportion of overall hospitalizations			✓
Proportion of ACSC Hospitalizations by Condition			✓
Change ACSC by condition as proportion of overall hospitalizations			✓
Full Immunization Coverage Rates by Two Years of Age by Birth Cohort			✓
Vaccine by Diseases Protected Against and Coverage Rate			✓
Percentage of total bed days as alternative level of care (MCN)	✓	✓	✓
Territorial Admissions Committee Clients by Placement			✓

Performance Measurement Indicator	2011-2016 Strategic Plan	2011/2012 Annual Report	Quarterly Performance Measurement Report (Spring 2012)
Location (MCN)			
Injury - prevalence of falls in hospitals	✓	✓	✓
Number of Medical Travel Patients and Escorts			✓
Number of standards reviewed and implemented	✓	✓	
Percentage of total biomedical equipment replaced based on recommended life cycles	✓	✓	
Percentage of total value of HSS Centres scheduled for major upgrade or replacement	✓	✓	
Reduce the rates of hospital-acquired infections	✓	✓	
Timeliness of responses to identified adverse events	✓	✓	
Time it takes to staff a position	✓		
Percentage of staffing competitions completed within 8 weeks		✓	
The percentage of employees that indicate that they feel safe and supported in their work environment	✓	✓	
H&SS positions by age group and type			✓
H&SS positions by average years of service			✓
Employees by average age and years of service			✓
Vacancy rate for specialists			✓
Vacancy rate by type of nurse			✓
Vacancy rate by social worker			✓

Table 2: Number of Performance Measures by Document

Report/Document	*Number of Performance Measures*
2011–2016 Strategic Plan	36
2011/2012 Annual Report	36
Quarterly Performance Measurement Report (Spring 2012)	42
Distinct NWT HSS System Total	**75**

A total of 75 current performance measures were identified for the NWT HSS System. Of these 75 performance measures, 42 are included in the Quarterly Performance Measurement report and 36 are included in the most recent 2011-2016 Strategic Plan, and the 2011/2012 Annual Report (Table 2).

Almost all of the performance measures in the 2011/2012 Annual Report are the same as the performance measures in 2011-2016 Strategic Plan. However, most of the performance measures in the Quarterly Performance Measurement Report are different than those contained in the 2011-2016 Strategic Plan and 2011/2012 Annual Report. Although these performance measures are not exactly the same, many are variations of the same theme, creating duplications. This means that the actual number of current distinct performance measures for the NWT HSS system is smaller than 75.

3.3.1.1 Northwest Territories Health Status Report

In addition to the 75 performance measures listed above, the DHSS has provided a Health Status Report in 2005 and then again in 2010. It is intended to inform the public about the wellbeing of the population in general and report on the major determinants of in the Northwest Territories. This report contains approximately 100 health indicators that cover a number of topics including well-being, chronic and communicable diseases, mental health and addictions, child and infant health, health determinants and preventive services. The department is committed to publishing a health status report every 5 years.

3.3.2 Health and Social Services Authorities

Each of the eight HSSAs in the NWT HSS system publishes an annual report that includes performance measures relevant to each region. However, the performance measures reported by each HSSA are not consistent which creates challenges for system-wide reporting. The variation in the types of performance measures reported by each HSSA is a reflection of the different types of programs and services delivered by each HSSA as well as the varying capacities and methods used to collect data.

3.4 Current Capacity

The current capacity to collect the data and information that is required to inform the performance measures for the NWT HSS system varies across the territory, ranging from minimal to adequate. The degree to which data is collected manually versus electronically also varies throughout the territory. Some HSSAs are solely dependent on manual data collection and processing, some have established electronic data collection systems, while others use a combination of electronic and manual data collection. Overall, most client health information is still maintained in paper files at facilities across the territory. MNP was not able to identify any standardization that exists amongst and between the HSSAs. There was general consensus amongst those stakeholders consulted that any update to the accountability framework should not result in additional work effort by "front-line" staff.

3.4.1 Data Collection Challenges

MNP identified eight distinct challenges related to the collection of data and information for performance measurement including[8,9]:

- There is no standardization and consistency in the collection and management of data/information across the territory. Each HSSA collects data/information independently, creates independent data definitions, and uses the data/information collected uniquely. This impacts both the quality and consistency of the data/information collected within the system.
- The process for managing records across the territories is inconsistent.
- There is a mix of ICD-9 and ICD-10 coding systems used in the acute care facilities in the territory and each facility defines data elements differently. This results in data sets that are not consistent.
- The clinical systems implemented by HSSAs in the territory have been configured and deployed inconsistently resulting in fragmented data collection with different systems that are not linked to each other.
- There is no standardized data capture and reporting systems for mental health and addictions programs and services.

[8] Data Warehouse Preliminary Analysis: Current State Assessment Report. Sierra Systems 2007.
[9] Based on consultations with stakeholders.

- The sharing of information between HSSAs is limited.
- The sharing of information along points in the continuum of care for patients is limited.
- The sharing of information between program areas such as public health and home care is limited.
- The cleansing and validation of the data collected is limited.

Stakeholder"s preliminary thoughts for addressing these challenges included:

- Using the interoperable Electronic Health Record (iEHR) to standardize the collection and management of data across the territory.
- Centralizing the collection, cleansing, analyses, and reporting of data.

4.0 Other Jurisdictions Insights

MNP examined the approach to health and social services system accountability in three other Canadian provinces including Alberta, Saskatchewan and Nova Scotia. The information was obtained through a combination of internet research and interviews with provincial representatives. Please note that MNP was unable to interview representatives from the province of Nova Scotia[10]. Indicators that these jurisdictions use were considered when the initial inventory of indicators was developed for the NWT HSS performance measurement framework detailed in Sections 8.2 and 8.3.

Key findings from other jurisdictions that were used to inform development of the recommended accountability framework and performance measurement framework included the following.

- While each jurisdiction articulates their performance measures uniquely, thematically there are significant similarities between them.
    - It should be noted, that the uniqueness of each jurisdictions performance measures are indicative of the current lack of a national focus. Nationally, the health sector is significantly ahead of the child welfare sector in regard to developing a national perspective, led in large part by the work of the Canadian Institute for Health Information (CIHI) discussed in more detail in Section 5.0 of the report. In 2009, Trocme, MacLaurin, Fallon, et al from The Centre for Research on Children and Families & Centres of Excellence for Children"s Well-Being report that "While this is one of the most high risk groups of children in Canada, there is currently no common framework for tracking how well children receiving child welfare services are doing.[11]" They present a common set of indicators to track outcomes for these children their National Child Welfare Outcomes Indicator Matrix.
- Unlike in the NWT, all three of the other jurisdictions reviewed have a separate accountability frameworks and performance measurement indicators for their respective health and social service sectors.
- The number of performance measures these other jurisdictions use range from 9 for Saskatchewan Health to 21 for Nova Scotia"s Department of Health and Wellness. These relatively small numbers of indicators across jurisdictions are consistent with what MNP recommends for the NWTs DHSS.
- The currency of each jurisdictions framework supports the national trend for examining health and social service system accountabilities. Each jurisdiction is wrestling with similar issues to that faced by the NWT in regard to establishing an environment of increased accountability and ability to report on system performance.

Collectively, a review of these jurisdictions practices in regard to accountability and performance management validate NWTs focus on this element of their Health and Social Service System and ultimately the accountability and performance frameworks recommended in Sections 7.0 and 8.0 respectively. While unique to NWT, the recommended frameworks were informed by other jurisdictions practices providing a degree of assurance that they are sound and adequately consider what some may define as „common practice".

Unique to the performance framework recommended for NWTs Health and Social Service System, and as far as MNP knows, the first of its kind in Canada, is the alignment of the framework with the Canadian Institute of Health Information"s (CIHI) Health System Reporting Initiative, detailed in Section 5.0. Basing their accountability framework on CIHI"s work should position NWT well in the national landscape of indicator development.

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[10] Detail regarding findings from each jurisdiction is included in Appendix C.

[11] Centre for Research on Children and Families & Centres of Excellence for Children"s Well-Being.. National Child Welfare Outcomes Indictor Matrix. September 2009.

5.0 Future State – What Could Be

This section provides a description of best practice approaches to health system performance measurement as well as identified principles and critical success factors for the development of a performance measurement system.

5.1 Best Practices

MNP reviewed numerous approaches to health system performance measurement. We believe three of these can be considered best practice and are most relevant to NWT HSS. Located in Canada, the United States and the United Kingdom these best practices provide significant insight into approaches that we believe should be used to guide development of your new performance measurement framework.

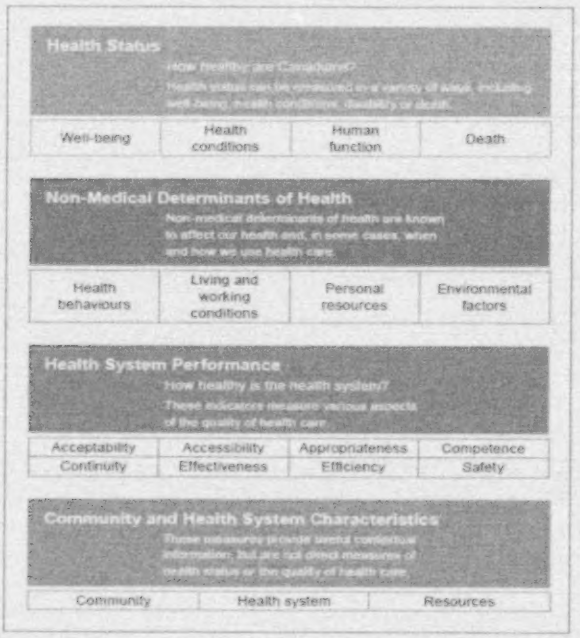
5.1.1 Canadian Institute for Health Information

5.1.1.1 Health Indicators Reporting with Stats Canada

The Canadian Institute for Health Information (CIHI), in collaboration with Statistics Canada, publishes an annual „Health Indicators" report. The report contains performance measures that assist in assessing the health of Canadians and the health of the Canadian health system. „Health Indicators 2012", the most recent version of the report and the 13th in the series, includes updates on more than 40 measures for Canadian regions.

Each of the performance measures included in the 2012 report is grouped into one of the five dimensions of the Health Indicator Framework developed by CIHI and Stats Canada (Figure 3). This framework has been internationally recognized.

Figure 3: Health Indicator Framework developed by CIHI and Health Canada[12]



[12] Taken from the „Health Indicators 2012" report.

5.1.1.2 Health System Performance Reporting Initiative[13]

CIHI recently started working on a Health System Performance reporting initiative (CIHI 2012). The initiative will be completed over a three year period from 2012 to 2015 and has four key objectives:

- To provide structured and coordinated pan-Canadian reporting on health system performance that is tailored to the information needs of different audiences, including the general public, provincial health ministries, regional health authorities and health care facilities;
- To produce analytical tools and products that support provincial and territorial health system improvement priorities;
- To work health system partners to build capacity for using and understanding performance measurements and tools; and
- To reduce "indicator chaos" in the health system by working with partners to identify which health indicators are most important, how they relate to each other, and how they can best support improvements to health care and the health of Canadians.

The initiative has five main work streams including:

- Health system performance measurement framework;
- Health system performance interactive public reporting;
- Integrated analytical environment;
- Research and analysis; and
- Capacity building.

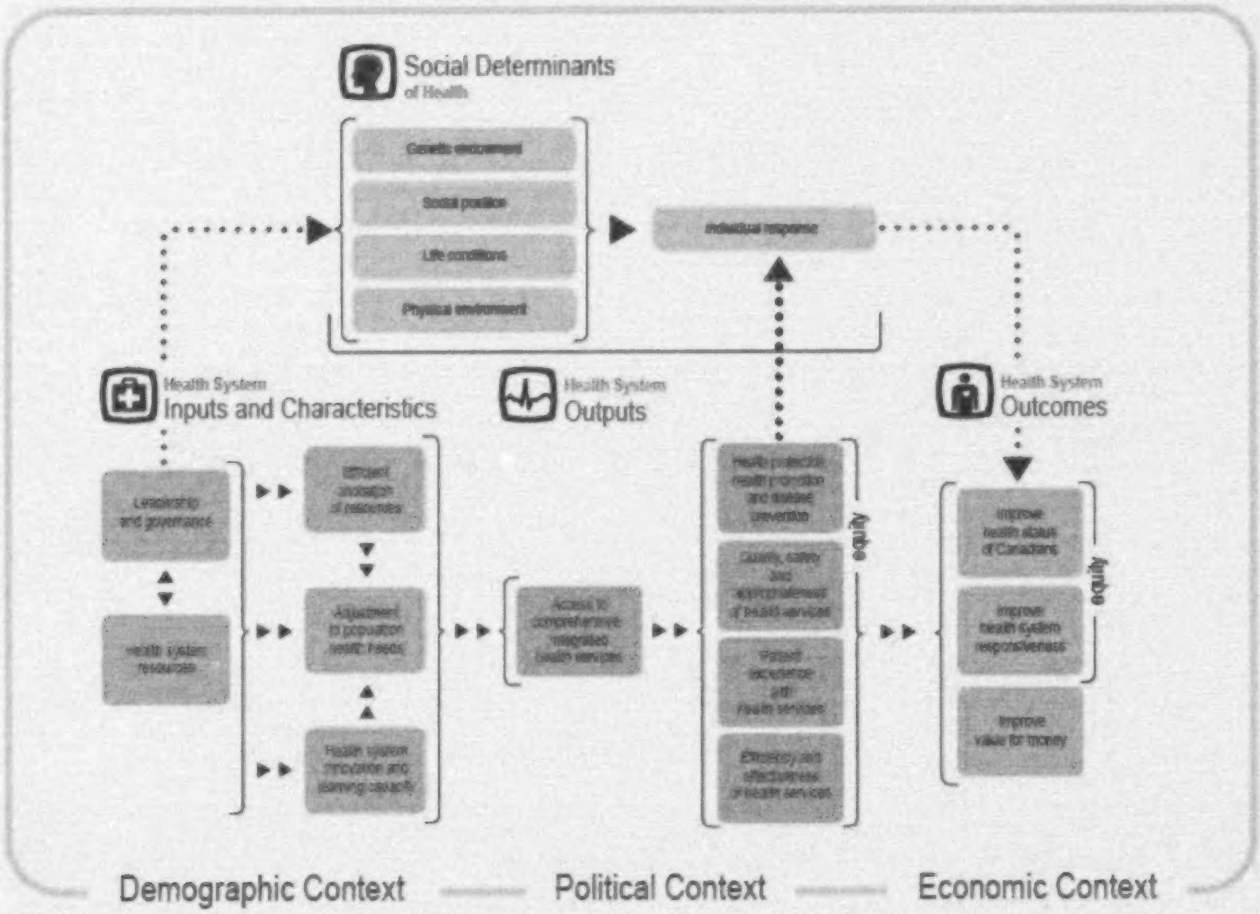
CIHI has developed a new framework for measuring health system performance (Figure 4). The framework builds on the previous framework developed by CIHI and Stats Canada (Figure 3). The new framework has four main quadrants including health system inputs, health system outputs, social determinants of health and health system outcomes. The framework also shows the relationship between each quadrant.

Under this initiative, CIHI will also develop interactive websites that have a focused set of cascading metrics that are meaningful and to useful to different audiences (Figure 5). CIHI recognizes that different audiences are interested in different aspects of health system performance and requires different levels of information.

CIHI"s proposed performance measurement reporting details four level of audience: public; provincial policy makers; regional health authorities; and points of care (hospitals, long-term care and primary care facilities). However, for this project, the scope of work only included development of accountability and performance frameworks that would address public and territorial policy maker"s audience levels. Reporting at the two lower levels currently does and will continue to exist in NWT, with HSSAs continuing to monitor and report appropriate indicators at the HSSA and point of care levels.

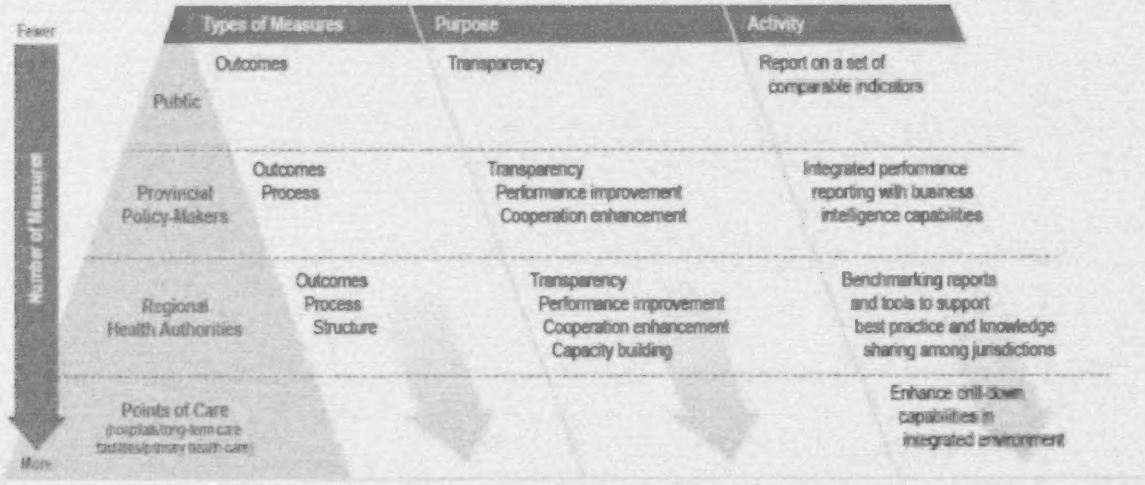
[13] Based on the document titled „Enhancing Pan-Canadian Health System Performance Reporting at CIHI". This document was provided to MNP by CIHI.

Figure 4: New CIHI Framework for Measuring Health System Performance[14]


Social Determinants of Health
Health System Inputs and Characteristics
Health System Outputs
Health System Outcomes
Leadership and governance
Health system resources
Effective stewardship of resources
Adjustment to population health needs
Health system innovation and learning capacity
Access to comprehensive integrated health services
Health protection, health promotion and disease prevention
Quality, safety and appropriateness of health services
Patient acceptance of Health services
Efficiency and effectiveness of health services
equity
Improve health status of Canadians
Improve health system responsiveness
Improve value for money
equity
Demographic Context
Political Context
Economic Context

[14] Based on the document titled „Enhancing Pan-Canadian Health System Performance Reporting at CIHI". This document was provided to MNP by CIHI.

Figure 5: CIHI Proposed Performance Measurement Reporting by Audience Type



5.1.2 Partners for Health Reform*plus*

Partners for Health Reformplus (PHRplus), was a five year project that ran from 2000 to 2005. The project was funded by the US Agency for International Development and focused on health policy and health system strengthening in developing and transitional countries. An article was published from the project titled „Accountability and Health Systems: Overview, Framework, and Strategies (Brinkerhoff 2003) that:

- Defines accountability;
- Provides an analytical framework for accountability and health service delivery systems;
- Describes the role of health sector actors in accountability; and
- Describes accountability-strengthening strategies.

The definitions of accountability from the article are included in Section 2.0 of this report. Accountability is defined as being answerable and having the obligation to answer questions regarding decisions and/or actions. Two aspects of accountability include:

- An informing aspect or transparency to report the activities and outputs of what was done; and
- A justification aspect to provide reasons to explain the why behind the activities and outputs. This aspect is linked to the World Health Organization"s notion of stewardship and good governance.

The availability and application of sanctions for the overseeing actor to impose on the accountable actor for not meeting targets gives "teeth" to accountability. However, sanctions without enforcement diminish accountability.

There are three types of accountability identified for health systems including financial accountability, performance accountability and political/democratic accountability (Brinkerhoff 2003). The definition and description for each type of accountability is as follows:

- **Financial Accountability** - tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. The operational basis for financial accountability begins with internal agency financial systems that follow uniform accounting rules and standards.

- **Performance Accountability** - demonstrating and accounting for performance in light of agreed upon performance targets. Its focus is on the services, outputs, and results or outcomes of public agencies and programs. Performance accountability is linked to financial accountability in that the financial resources to be accounted for are intended to produce goods, services, and benefits for citizens, but it is distinct in that financial accountability"s emphasis is on procedural compliance whereas performance accountability concentrates on results and in the case of a health and social services systems, health outcomes.
- **Political/Democratic Accountability** - has to do with the institutions, procedures, and mechanisms that seek to ensure that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens" interests, and responds to ongoing and emerging societal needs and concerns. The political process and elections are the main avenues for this type of accountability.

5.1.3 United Kingdom Department of Health

The National Health Service (NHS) is responsible for providing a number of health services in England including emergency and urgent care, hospital services, general practitioner services, pharmacy services, dental services, eye care services, mental health services and social services[15]. The UK Department of Health developed NHS Outcomes Framework to set out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board accountable for the health outcomes achieved by the health system (Department of Health 2010). This framework was first published in 2011/2012 and then updated in 2013/2014 to include a total of 63 indicators including 14 overarching indicators and 49 improvement area indicators (Appendix C). The purpose of the NHS Outcomes Framework is to:

- Provide a national level overview of how well the NHS is performing;
- Provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spending of public money; and
- Act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

The indicators in the framework have been organized into five domains which identify the national outcomes that the NHS should be working on to improve (Department of Health 2012). Within each domain, there are overarching indicators and improvement area indicators that focus on improving health and reducing health inequalities. The five domains include:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

MNP identified the NHS framework as a best practice and recommended it be part of the informing body of knowledge for development of NWT"s frameworks due to its focus on health outcomes. The five domains are all outcome related and focus on the „ultimate" goals of health and social services: positive outcomes for patients.

[15] http://www.nhs.uk/NHSEngland/AboutNHSservices/Pages/NHSServices.aspx

5.2 Principles

The Department of Health and Social services committed to four principles that must guide the development of a new accountability framework. MNP used these principles to guide our work.

- **Clarity** – Roles, responsibilities and performance expectations are clearly defined and communicated.
- **Efficiency** – Performance expectations must be in balance with capacity to deliver results, and must reflect human, fiscal and capital resources.
- **Effectiveness** – Reporting between all relevant stakeholders is meaningful, credible and timely and allows for informed decision making.
- **Flexibility** – Performance plans must allow for adjustments to be made based on review and feedback, and consequent changes to strategic directions and resource allocations, along with any changes in system structure.

5.3 Critical Success Factors

Based on the best practices research, other jurisdiction research, stakeholder input and application of our own experiences, MNP developed the following critical success factors for NWT HSSs consideration:

- **Keep it Simple** – Start small with performance measurement and develop over time. This will improve the probability of success and the ability to build off that success. Start with high-level system wide performance measures.
- **Anchor with Standards and Guidelines** – Use peer reviewed standards and/or guidelines as an anchor or benchmark for performance measurement.
- **Focus on Health & Social Service Outcomes and System Performance** – Focus on health and social service system performance measurement and outcomes rather than system processes.
- **Use Relevant Performance Measures** – Report on a mix of measures that are relevant to and reflective of the health and social services system including hospital based, non-hospital based, and community measures.
- **Availability of Data** – The ability to collect data that will inform performance measures is the driving force behind the feasibility of what can and cannot be reported.
- **Consistent Data Collection and Analysis** – Consistent data collection and analysis improves the quality of the data used for reporting. It is important to have confidence in the data being reported. Some jurisdictions analyze and manage data at the department of ministry level to ensure consistency and quality.
- **Communication** – Communication with key stakeholders during the development and implementation of the accountability framework is important. Buy-in and utilization of the framework will improve if stakeholders are informed of the reasons for the framework during the development stage. Ongoing communication and reporting to stakeholders is also required after implementation of the framework to maintain buy-in and participation.

6.0 Gaps in Current Accountability Framework

By considering current state for the NWT HSS system (Section 3.0) and subsequently considering other jurisdictions (Section 4.0) and best practice research (Section 5.0) two distinct points representing where NWT is now and where it could be in regard to an accountability framework, can be established. With these two "goal posts" established, the gap between them can be readily determined. MNP has articulated a summarized list of the strengths and gaps with the current NWT HSS system Accountability Framework (Table 3) and a summarized list of the current strengths and gaps for measuring the performance of the NWT HSS system (Table 4). These gaps effectively define the elements that need to be developed during the next phase of work where the NWT HSSs accountability framework is defined.

Table 3: Strengths and Gaps of Current Accountability Framework

Dimension	Strength	Gap
Definition of accountability	✓	
Definitions of other key terms	✓	
Roles, responsibilities and accountabilities articulated	✓	
Roles, responsibilities and accountabilities defined		✓
Service level agreements/sanctions		✓
Domains/categories of performance measurement		✓
System performance measures included		✓
Performance targets based on established standards		✓
Reporting requirements documented		✓
Framework updated on regular basis		✓
Framework incorporates best practice		✓
Stakeholder awareness of framework		✓
Linked to current strategic plan		✓

Table 4: Strengths and Gaps of Current Performance Measurement

Dimension	Strength	Gap
Standard set of performance measures reported for HSS system		✓
Performance measures in strategic plan linked to annual report	✓	
Performance measures informed through consistent data collection and analysis		✓
Capacity exists to collect data for performance measures throughout the system		✓
Regular reporting of performance measures	✓	
Communication and awareness of performance measures/reporting		✓
Consistent organization and categorization of performance measures in all reports		✓
Stakeholder buy-in to system performance measurement		✓

7.0 Recommendations: Accountability Framework

7.1 Components of a New Accountability Framework

As defined in the scope of this project, the desired outcome is: *Clear and appropriate accountabilities and reporting functions within the NWT Health and Social Services System to ensure that credible and timely information on the ongoing relevance and performance of all HSS program spending is available and is used to support evidence-based decision-making with respect to policy development, expenditure management and program quality assurance.* Accordingly, MNP was engaged to assist with:

- The development of an overall accountability framework that outlines performance reporting requirements for key target audiences, including timing, indicators, and data collection responsibilities.

Work completed by MNP in 2011 identified a number of components of accountability that are directly applicable and relevant to this project (Appendix D). Items discussed in this document include:

- Roles and responsibilities;
- Reporting accountabilities;
- Instruments or tools for accountability; and
- Accountability agreements.

In this section of the report we provide a visual representation of MNPs recommended accountability framework for the NWT Health and Social Service System, with more detail on possible components of a framework provided in Appendix D.

Section 8.0 of the report details MNPs recommended performance framework.

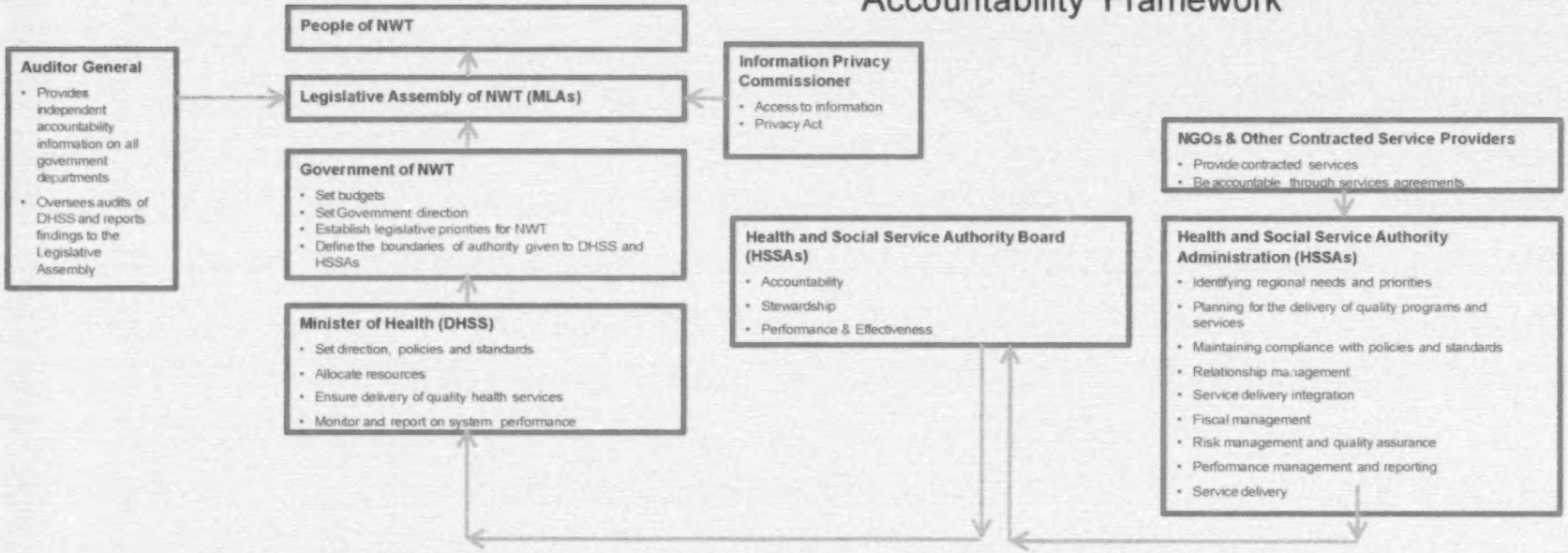
7.2 Recommended Accountability Framework

Using the accountability framework developed in the 2011 MNP report as a starting point (Appendix D), the other jurisdiction research completed (Appendix C) was then utilized to inform refinement of an accountability framework for NWTs Health and Social Services System.

Note that at the time of completion of this project there is active discussion within NWT to modify the current governance system for health and social services. As it is difficult to recommend a final accountability framework until such time as the governance model has been determined, MNP has provided a high-level accountability framework on the page that follows, but is recommending that a more detailed accountability framework be developed once the governance of NWT's health and social services system is finalized.

The high-level accountability framework presented details the accountability relationships and key responsibilities for the „players" in NWTs Health and Social Service System as it exists today. Detail regarding roles and responsibilities, reporting accountabilities, mechanism and tools that can be used to manage system accountability; including an outline for an accountability agreement can be found in Appendix D.

NWT Health and Social Service System Accountability Framework


People of NWT
Auditor General
• Provides independent accountability information on all government departments
• Oversees audits of DHSS and reports findings to the Legislative Assembly
Legislative Assembly of NWT (MLAs)
Information Privacy Commissioner
• Access to information
• Privacy Act
Government of NWT
• Set budgets
• Set Government direction
• Establish legislative priorities for NWT
• Define the boundaries of authority given to DHSS and HSSAs
Minister of Health (DHSS)
• Set direction, policies and standards
• Allocate resources
• Ensure delivery of quality health services
• Monitor and report on system performance
Health and Social Service Authority Board (HSSAs)
• Accountability
• Stewardship
• Performance & Effectiveness
NGOs & Other Contracted Service Providers
• Provide contracted services
• Be accountable through services agreements
Health and Social Service Authority Administration (HSSAs)
• identifying regional needs and priorities
• Planning for the delivery of quality programs and services
• Maintaining compliance with policies and standards
• Relationship management
• Service delivery integration
• Fiscal management
• Risk management and quality assurance
• Performance management and reporting
• Service delivery

8.0 Recommendations: Performance Framework

One specific recommendation made in the 2011 MNP report (Appendix C) was to develop system and program performance indicators. *"To understand HSSA and system performance, consistent system and program performance indicators must be developed. Data collection tools and resources will also be required to ensure indicators are measured and data is collected, analyzed and findings are presented in required reports. This will increase the system's ability to ensure compliance and control, quality assurance, and risk management."*

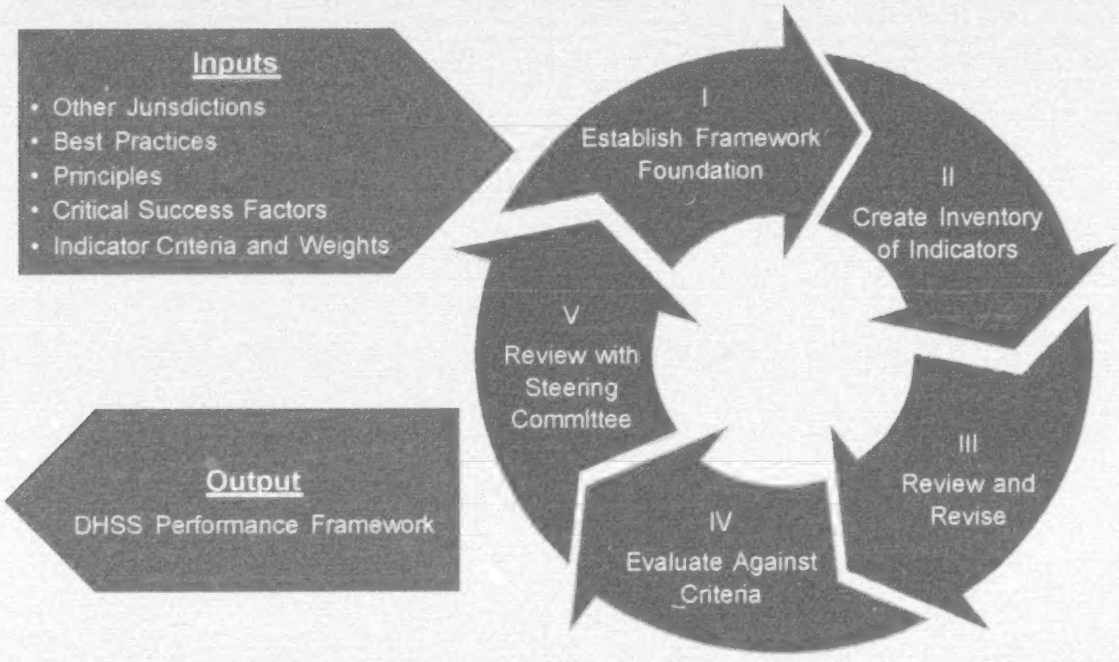
This section details recommendations for an NWT Health and Social Service performance framework including:

- The performance framework development approach;
- The performance measurement indicators;
- Frequency of reporting;
- Types of reporting;
- Formats of reports; and
- Report audiences.

8.1 Performance Framework Development Approach

The approach MNP used to develop the performance framework is summarized in the graphic below (Figure 6).

Figure 6: Performance Framework Development Approach



8.1.1 Inputs

8.1.1.1 Other Jurisdictions

- MNP examined the approach to health and social services system accountability in three other Canadian provinces including:
  - Alberta;
  - Saskatchewan; and
  - Nova Scotia
- Detailed documentation regarding these three jurisdictions practices for both health and social services are contained in Appendix C of this report
- Indicators that these jurisdictions use were part of the inventory that was considered for the NWT HSS system

8.1.1.2 Best Practices

- MNP reviewed numerous approaches to health system accountability and performance measurement
- MNP identified three approaches that can be considered best practice and are most relevant to the NWT HSS system
- These best practices provided significant insight into approaches that we used to guide development of the new accountability framework, and in particular the indicators
  - Canadian Institute for Health Information – Performance Measurement Framework
  - Partners for Health Reformplus (PHRplus) - „Accountability and Health Systems: Overview, Framework, and Strategies" (Brinkerhoff 2003)
  - The UK Department of Health - NHS Outcomes Framework (*sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board accountable for the results achieved by the health system*)

8.1.1.3 Framework Principles (DHSS)

- **Clarity** – Roles, responsibilities and performance expectations are clearly defined and communicated
- **Efficiency** – Performance expectations must be in balance with capacity to deliver results, and must reflect human, fiscal and capital resources
- **Effectiveness** – Reporting between all relevant stakeholders is meaningful, credible and timely and allows for informed decision making
- **Flexibility** – Performance plans must allow for adjustments to be made based on review and feedback, and consequent changes to strategic directions and resource allocations, along with any changes in system structure

8.1.1.4 Critical Success Factors (MNP)

- **Keep it Simple** – Start small with high-level system wide performance measures and develop over time
- **Anchor with Standards and Guidelines** – Use peer reviewed standards and/or guidelines as an anchor or benchmark for performance measurement
- **Focus on Health Outcomes** – Focus health system performance measurement on health outcomes rather than health system processes
- **Use Relevant Performance Measures** – Report on a mix of measures that are relevant to and reflective of the health system including some hospital based and non-hospital based measures

- **Availability of Data** – The ability to collect data that will inform performance measures is the driving force behind the feasibility of what can and cannot be reported
- **Consistent Data Collection and Analysis** – Consistent data collection and analysis improves the quality of the data used for reporting. It is important to have confidence in the data being reported
- **Communication** – Communication with key stakeholders during the development and implementation of the accountability framework is important. Buy-in and utilization of the framework will improve if stakeholders are informed of the reasons for the framework during the development stage

8.1.1.5 Indicator Criteria and Weights

- Nine criteria against which indicator options were measured were created, and then weighted by the Steering Committee
- These criteria are as follows:
    1. *Reliable and Valid Data Available* – Considers the reliability and validity of the data
    2. *Capacity to Collect Data Exists* – Considers the capacity requirements to collect and report on the measure
    3. *Allows for Target Creation* – Considers whether the measure allows targets to be set
    4. *Performance Measure is Meaningful to the Public* – Considers whether the measure will be meaningful to the public
    5. *Performance Measure is Meaningful to the NWT HSS System* – Considers whether the measure will be meaningful to the NWT HSS system
    6. *Anchored with Standards and Guidelines* – Considers whether the performance measure allows for comparison to peer reviewed standards and/or guidelines
    7. *Allows for Decision Making* – Considers the degree to which having the information will allow the NWT HSS system to make policy, strategic and/or operational decisions
    8. *Focuses on System Outcomes and Performance* – Considers the degree to which the measure focuses on health and social service system performance measurement and health outcomes rather than processes
    9. *Degree to Which the HSS System Can Impact Change* – Considers the degree to which the NWT HSS system has the ability to impact change
- To determine the weightings of the feasibility criteria, each criterion was compared against the other
- A score was assigned for each comparison between two criteria based on a scale (Figure 7)
- Scores were then be summed for each criterion and weighted against the total scores to arrive at the aggregate weighting (Figures 8, and 9).

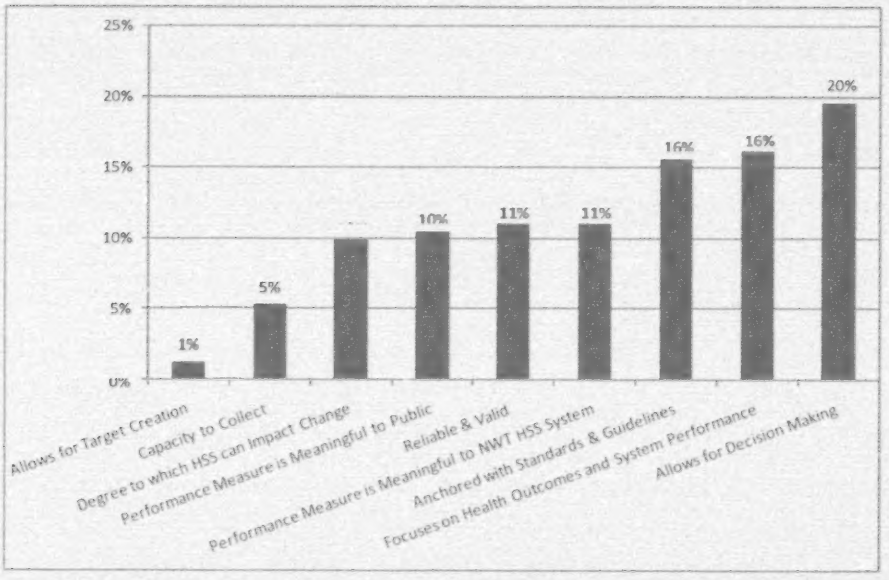
Figure 7: Weighting Legend

Description	Score
Criterion is **less important** than its comparison	0.2
Criterion is **equally important** as its comparison	1.0
Criterion is **more important** than is comparison	5.0

Figure 8: Indicator Criteria and Weights

	1) Reliable and Valid Data Available	2) Capacity to Collect Data	3) Allows for Target Creation	4) Performance Measure is Meaningful to Public	5) Performance Measure is Meaningful to NWT HSS	6) Anchored with Standards and Guidelines	7) Allows for Decision Making	8) Focuses on Health Outcomes and System Performance	9) Degree to which HSS can impact change	Total Value	Individual Weighting
1) Reliable and Valid Data Available		5.0	5.0	1.0	1.0	0.2	1.0	1.0	1.0	15.2	11%
2) Capacity to Collect Data	0.2		5.0	1.0	0.2	0.2	0.2	0.2	0.2	7.2	5%
3) Allows for Target Creation	0.2	0.2		0.2	0.2	0.2	0.2	0.2	0.2	1.6	1%
4) Performance Measure is Meaningful to Public	1.0	1.0	5.0		1.0	0.2	0.2	1.0	5.0	14.4	10%
5) Performance Measure is Meaningful to NWT HSS System	1.0	5.0	5.0	1.0		1.0	1.0	0.2	1.0	16.2	11%
6) Anchored with Standards and Guidelines	5.0	5.0	5.0	5.0	1.0		0.2	0.2	5.0	21.4	16%
7) Allows for Decision Making	1.0	5.0	5.0	5.0	1.0	5.0		5.0	5.0	27.0	20%
8) Focuses on Health Outcomes and System Performance	1.0	5.0	5.0	1.0	5.0	5.0	0.2		1.0	22.2	16%
9) Degree to which HSS can impact change	1.0	5.0	5.0	0.2	1.0	0.2	0.2	1.0		13.6	10%

Figure 9: Indicator Criteria and Weights

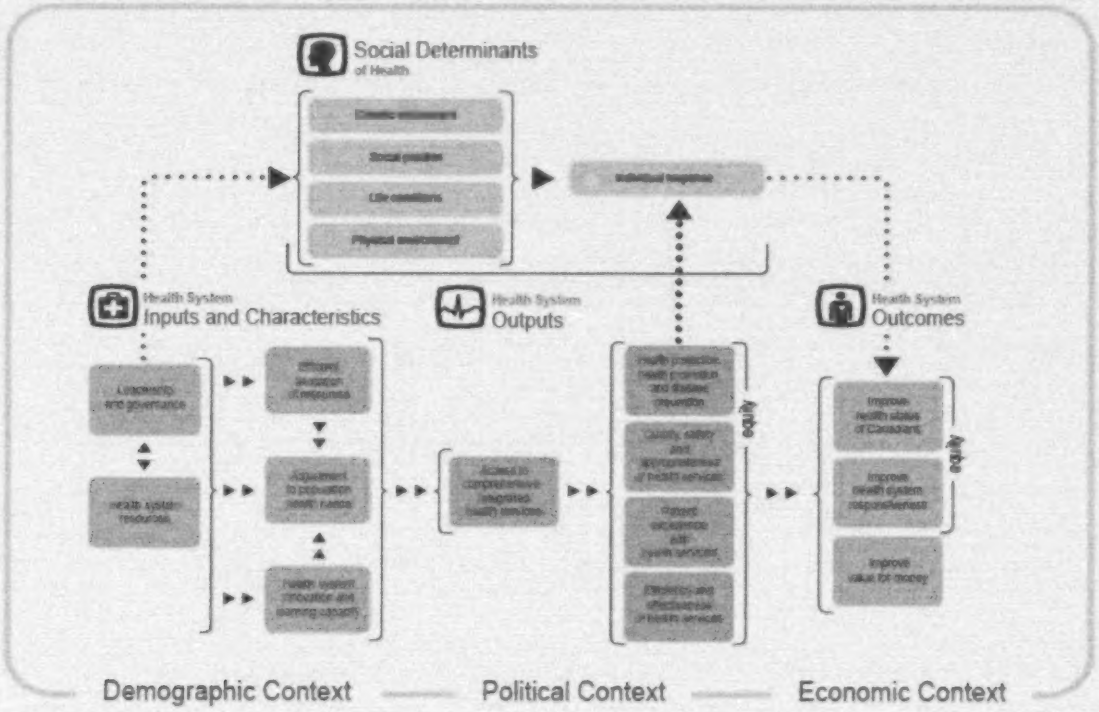


8.1.2 Establish Framework Foundation

- In reviewing other jurisdictions frameworks as well as leading practices in Canada, MNP recommended using the *Canadian Institute for Health Information – Performance Measurement Framework* as the foundation (Figure 10):
  - Can readily be adapted to incorporate both health and social services elements which is critical to the NWT HSS system framework.
    - Currently, there is a lack of a national framework for child welfare and social services and more work has been done in the health sector in this regard, leading to MNPs recommendation to utilize CIHIs framework as the basis for the NWT framework.
    - DHSS is encouraged to continue to follow the work of the National Child Welfare Outcomes Indicator Matrix and incorporate advancements in social service indicators as this work progresses nationally.
  - Is comprised of four equally important and interrelated quadrants that represents a system:
    - Health and Social System Inputs and Characteristics
    - Health and Social System Outputs
    - Health and Social System Outcomes
    - Social Determinants of Health
  - Was designed to allow system managers and policy makers to assess system performance
  - Based on recognized literature and research
  - Has potential to be a capacity saver for the Department of HSS

Note that as stated earlier in this report, CIHI"s proposed performance measurement reporting details four level of audience: public; provincial policy makers; regional health authorities; and points of care (hospitals, long-term care and primary care facilities). However, for this project, the scope of work only included development of accountability and performance frameworks that would address public and territorial policy maker"s audience levels. Reporting at the two lower levels currently does and will continue to exist in NWT, with HSSAs continuing to monitor and report appropriate indicators at the HSSA and point of care levels.

Figure 10: CIHI Framework



The quadrants and performance dimensions of the framework are defined below.

- **Health and social system inputs and characteristics** – refer to the relatively stable characteristics of the health and social services system, including:
  - Governance and leadership capacities in the system,
  - Resources available for use,
  - Distribution and allocation of those resources,
  - Capacity to adjust and adapt to meet population health needs, and
  - Innovation and learning capacities of the system
- **Health and social system outputs** – are the immediate results of activities undertaken by the health and social services system. Common outputs include the delivery of accessible, timely and effective health and social services
- **Health and social system outcomes** – correspond to the intrinsic goals of the health and social services system. These outcomes are:
  - Improvement of the level and distribution of health in the population,
  - Health and social services system"s responsiveness to the needs and demands of the people of NWT, and
  - Value for money to ensure system sustainability
- **Social determinants of health** – represent the factors outside the health and social services system that influence the health of a population. In the framework these include:
  - Genetic endowment,
  - Social position,
  - Life conditions, and

- Physical environment

More detail regarding each of the quadrants and dimensions definitions can be located in the Canadian Institute for Health Information 2012 publication, "A Performance Measurement Framework for the Canadian Health System". https://secure.cihi.ca/free_products/HSP-Framework-ENweb.pdf.

8.1.3 Create Inventory of Indicators

- An inventory of 55 initial indicators was created using all the inputs to inform their development:
  - Other jurisdictions,
  - Best practices,
  - Principles,
  - Critical success factors, and
  - Indictor criteria

8.1.4 Review and Revise

- The indicators were circulated for comment and/or discussed with:
  - Version 1.0
    - Director, Corporate Planning, Reporting and Evaluation
  - Version 2.0
    - Director, Corporate Planning, Reporting and Evaluation
    - Senior Health Analyst, Corporate Planning, Evaluation and Analysis Unit
  - Version 3.0
    - Director, Corporate Planning, Reporting and Evaluation
    - Circulated to Steering Committee representatives
  - Version 4.0
    - Senior Health Analyst, Corporate Planning, Evaluation and Analysis Unit
  - Version 5.0
    - Steering Committee
- Indicators were removed, new ones added, and others were modified, resulting in the initial list of 55 indicators being reduced to 42.

8.1.5 Evaluate Against Criteria

- The 42 indicators were then evaluated using the nine weighted criteria and a three-point scale
- Each of the 42 indicators received a weighted score *(the higher the score the "better" the indicator met the criteria, implying the "better" the metric)*
- One of the criteria considered the capacity for collecting the needed data
- Despite this criteria receiving the second lowest weight, (5%), in completing the reviews it became apparent there was going to be a real issue with collecting data for many of the proposed indicators
- Accordingly it was recommended that any indicator receiving a score of 1 (poorly meets) be eliminated from further consideration
- This further reduced the number of indicators from 42 to 21
- This resulted in MNP recommending the inclusion of 21 indicators.

8.1.6 Review with Steering Committee

- The recommended 21 indicators were reviewed with the Steering Committee for final inclusion decision.
- Through this discussion some indicators were removed and new ones added resulting in a total of 25 indicators being selected (Appendix E)
- A total of 18 indicators were not selected (Appendix F). There were a number of non-selected indicators that were identified as priorities for DHSS to pursue in the future and these have been highlighted in Appendix F.

8.2 Performance Measurement Indicators

The 25 selected performance measurement indicators are summarized (Table 5) and detailed in Appendix G. Note that some of the indicators proposed may eventually be reported in ways that vary from the manner recommended (e.g. more or less detail, in rate vs. number format etc) following implementation.

Table 5: Selected Performance Indicators

Selected Performance Indicators
Inputs and Characteristics
1. The quarterly proportion of actual HSSA expense under or over projected expenses (variance reporting)
2. The proportion of HSSAs with published, current operating (health and social service) plan and annual report
3. The rate of critical incidents per 1,000 employee days worked
4. Vacancy rate per staffing category (Physician, Nursing, Allied Health, Social Worker)
5. Average wait times by type of surgery (time of booking to surgery)*
6. Average wait time for offer of placement in a long-term care facility
7. Rate of adoption of newly established clinical standards of care
Outputs
8. Utilization rate of tele-health technology for patient care activities
9. Number (%) of children receiving child welfare care in their home community: by age group and demographic (Aboriginal)
10. The number of patients and the number of escorts using the medical travel program per fiscal year
11. Proportion of the population receiving: full immunization coverage by the age of two years
12. Incidence **rate** of sexually transmitted infection in NWT
13. Average number of critical incidents reported: a) per 1,000 inpatient bed days, and b) per 1,000 outpatient visits
14. Average number of placements per year per child: Aboriginal and non-Aboriginal
15. Percentage of NWT residents satisfied or very satisfied with the health and/or social service care received in NWT in the past year (e.g. Hospital year 1, LTC year 2, Primary Health year 3)
16. Percentage of no-shows (cancellations) that could not be rescheduled: general, specialist, and by HSSA

Selected Performance Indicators
Outcomes
17. Incidence rate of cancer by type
18. Incidence rate of diabetes
19. Self-reported health status of NWT residents
20. Average length of time between specialist referral and specialist appointment
Social Determinants of Health
21. The proportion of children who are developing well at school entry
22. Percentage of NWT population who smoke
23. Percentage of NWT population with reported substance abuse issues
24. Proportion of all children placed in homes where at least one of the caregivers is from the same culture as the child
25. Percentage of NWT population who are obese

*This indicator is located in two dimensions of the performance framework (Efficient Allocation of Resources, and Improve Health and Social Service System Responsiveness)

8.3 Reporting Frequency

The recommended frequency of reporting for all indicators is annual. The DHSS may choose to internally report on select indicators with greater or lesser frequency however, annual reporting to the public and the GNWT legislature is recommended. Given the data collection challenges detailed in Section 3.4.1 of the report, one of the filters used to assess the selected indicators was the capacity of the GNWT to collect the data (Figure 8). The GNWT will have to remain cognizant of its capacity for collecting the required data for the twenty-five selected indicators. Changes to the recommended reporting frequency and/or the number of indicators reported on may need to be made as the GNWT implements the recommendations and some of the indicators may not be reported on in initial reports due to unforeseeable challenges and times constraints involved in establishing data capture and reporting systems.

8.4 Reporting Formats

Selecting a reporting format that is appealing to and easily understood by the audiences is important. Historically, the DHSS has utilized a number of formats and significant effort has been applied to developing reports that will be useful and appealing to their audience.

- Internally, a "Performance Measures" report was developed and implemented in the spring of 2012 to report quarterly on a set of indicators.
- Externally, the 2011/2012 NWT Health and Social Services Annual Report: Measuring Success and Focusing on Results was published in October 2012 to report on progress against the priorities and action articulated in the DHSS Strategic Plan.

MNP believes these reports are sound and that redevelopment is not required or recommended. Utilizing graphical representation of results is likely the most impactful for a reader, however supplementing the

graphical representation with narrative explanation is required to provide robust information. MNP is recommending that information on each reported indicator be structured under five headings as follows:

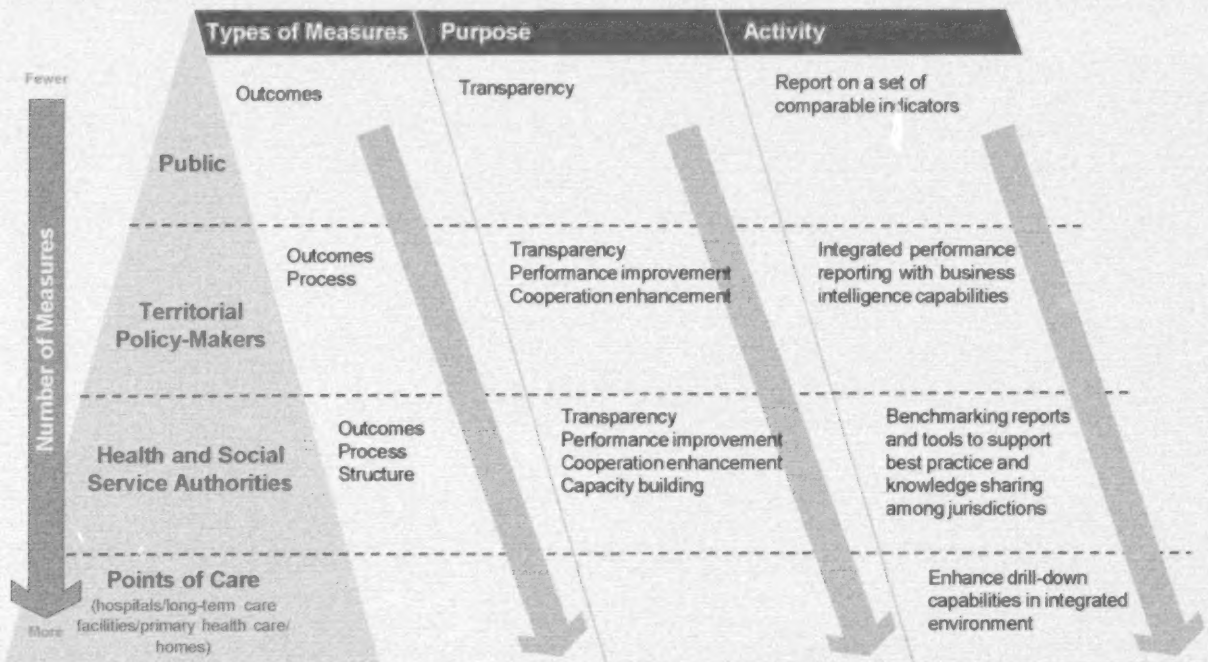
- Indicator Title;
- What is Being Measured;
- Why is This of Interest;
- What does this tell us; and
- How Are We Doing.

MNP has developed narrative for each of the selected indicators under each of these headings that are detailed in Appendix G.

8.5 Audiences

Guiding the development of the performance indicators was the understanding that they were meant to be at the "system" level rather than the HSSA level and to be utilized to report primarily to two groups: the public; and the GNWT decision –makers. Accordingly, the types of measures required and their purpose will be different than would be required to report to different groups such as health and social service authorities or points of care (Figure 11). A HSSA would require more detailed reporting in order to have information available that allows for operational decision making, whereas at the territorial policy maker level higher level, trending information will be more valuable to understand which parts of the system are working well and which are not. This is not suggesting that more detailed performance reporting should not be completed by HSSAs, but rather the focus of this project was to develop system level reporting.

Figure 11: Reporting Audiences



*Adapted from Canadian Institute of Health Information – Performance Measurement Framework

8.6 Updates to Framework

It is recommended that the framework is formally reviewed on an annual basis. Further, it is recommended that as the indicators are reported on, feedback should be sought from both the public and GNWT decision makers re: their value and usefulness that in turn, may drive the need to modify the indicators. While the intent of the framework is to ensure that it reflects the DHSSs core business and this is not likely to change dramatically over time, there may be instances when changes are required as a result of emerging strategic priorities and/or as new sources of information become operational (e.g. electronic medical records) allowing for the development of more effective performance measurements. The DHSS is cautioned to carefully consider changes before making them, ensuring that the same criteria and process used to select the original indicators is utilized to assess potential new additions. In particular, due attention should be provided to balance the desire to enhance the indicators with the capacity requirements. In other words maintaining the simplicity of the indicators and framework is felt to be critical to the ongoing ability of the DHSS to report in a timely and effective manner. One way to ensure the purpose of the framework is understood will be communications regarding

Connecting and linking the performance framework to the DHSS strategic plan will be a process that can be anticipated to unfold in the future. When DHSS embarks on the development of a new strategic plan, using the performance framework as input into its development and vice-versa is recommended. As the strategic plan evolves so too will the need to evolve the performance framework, in order ensure as much alignment as possible.

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Appendix A: DHSS Reporting

Reporting Obligations Questionnaire

As part of the Current State Assessment review of the Data Warehouse Preliminary Analysis project the reporting obligations of each division need to be identified. Any related information already identified as part of the Information Needs interview process conducted during the past March and April are shown under the appropriate tables that follow. Please verify this information and augment as necessary.
In particular, the information fields requested are:

Division & Division Group:	The name of your Division and if applicable, the name of your group (e.g. Division: Territorial/Integrated Services. Division Group: Continuing Care)
Contributor Name:	Your name. Contributing on behalf of your group
Reporting Obligations:	Identify the name of each report that your group requires to produce for internal DH&SS groups or external entities.
Notes	Any notes that help describe the particular report in addition to its name
Data Sources:	Identify the source systems used to contribute the required information. If you are not sure of the systems involved then please identify who generates the report for you
Recipient:	Identify the intended recipient of the report
Frequency:	Identify the how often you need to produce the report (e.g. monthly, annually etc)
Turn Around Time:	Identify the period of time that you have available to produce the report (i.e.: from the point of time the source data is available (e.g. HMIS data received) to the point that the report is generated)
Issues:	Identify issues affecting the generation of the report (particular emphasis on issues that are not identified as part of the interview process)
Priority:	High/ Medium/ Low

Division	Division Group	Contributor Name
Policy, Legislation and Communication		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Annual Canada Health Act (NWT portion).	The P.A.R. division provides the data and Policy division provides the narrative and submits the document to the Federal Government		Health Canada	Annual		
Professional Registry reports		Severed photocopies of applications	CIHI	Annual	1 yr.	Very labour intensive to manually prepare information
FMBS: Variance Reports		FIS		Quarterly		

Division	Division Group	Contributor Name
Financial Management		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
N/A	The Board shall provide the Department with financial statements and reports as required in Schedule C in accordance with part IX of the *Financial Administration Act*					Is this referring to the Core Funding Contribution Agreement? See below.
HSSA Business Plan	Authorities shall submit a business plan to the Minister on an annual basis		Minister	Annual		Authorities not required to submit annual business plans
HSSA Budget	Shall Submit a budget to the Minister on an annual basis		Minister	Annual		In the past couple of years, we have received deficit budgets from Authorities that could not be approved.
DH&SS Funds Expended	Shall account to the Department for the funds expended in the Contribution Agreement		Minister	Annual		Is this referring to the Core Funding Contribution Agreement? Authorities are funded under annual Core Funding Contribution Agreements. Schedule C of those agreements lay out annual reporting requirements.
Expenditures by Community	In order to fulfill this obligation, we require the information from the Authorities.		Financial Management Board	Quarterly Reports are due three weeks after each quarter		We don"t require this reporting of the Authorities. Perhaps this is referencing GNWT Geographic Tracking exercise of former years. No longer required to report on this.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Annual Hospital Survey	The completion of Annual reports are a federally legislated requirement The Department performs a coordination function in gathering and compiling this information within the territory. HSSA"s submit to Department end of September to ensure time to compile and send to CIHI by Oct 31 deadline.		CIHI	Annual Due October 31 of each year		Authorities and Dept have been getting better at submitting data and meeting deadlines. Our score by CIHI on the data can be improved however, as Authorities are currently not reporting statistical data at the minimum reporting requirements. Department has not yet pushed for more statistical data reporting in this format. Focus for past couple of years has been improving the reporting of financial data.
Expenditure Management Report (Variance)	The Department is required to submit a monthly report to the Department of Finance explaining the year-to-date expenditures as well as the year end projected expenditures.	Program managers and SAM	Department of Finance Department of Finance provides summary information to FMB.	Monthly - Due 15 days after each month end. Annual - due during Year end reporting schedule		We have had issues of getting program manager feedback in a timely manner to complete the variance by deadline. This has recently been improving. Typically one week late in submission. Projections can be suspect – often program managers overestimating what year end expenses will be. Critical that this information be as accurate as possible as it affects decisions to move forward with requests for Supplementary Funding.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Information Item: Authority Variances		Authority Variance Submissions	Department of Finance / FMB	Due 45 days after the end of each financial quarter.		Directed by FMB to provide an Info Item on the status of Authority projected variances. Meeting deadline dependent upon the timeliness and quality of information provided by the Authorities. Information provided in the Info Item can impact the Departments ability to access Supplementary Funding.
HSSA Audited Financial Statements			Minister Department of Finance also receives copies. Government Accounting for Consolidation purposes Budgeting and Evaluation for assessment purposes.	Annual Audited financial statements are due by June 30		Continue to work to ensure the reports are per the required format in the annual Instructions to Auditors. Need to ensure information is at a level of detail appropriate for consolidation purposes of the GNWT. Working towards having the AFS tie directly to the approved Chart of Accounts.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Contracts > 5K List	Government Accountability	• SAM • Contracts Registry and Reporting System	Department of ITI Public	Regular data entry and Annual reconciliation		Some contracts are out of scope for the registry Ability to keep staff in the Authorities trained is sometimes a struggle – with turnover and the responsibility for training with ITI.

Division	Division Group	Contributor Name
Population Health		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Communicable disease occurrence information reported within 24 hours and 7days according to the schedules under the Communicable Disease Regulations under PHA		Laboratories & Clinicians Frontline doctors and nurses report to health protection unit via phone or fax	Chief Medical Health Officer and the Registrar of Disease Registries Health Canada	Monthly Based on Occurrence Monthly	24 hours or less	
TB Annual Report		Lab, clinicians &IPHIS	Regional Report Yearly International circumpolar Surveillance PHAC	Yearly		
STI Audits & Reports		Lab, Clinical	Individual communities clinics/RHSS & CPHO	Quarterly		
Enhance Pneumococcal, meningococcal, Heamophilus B Reporting		Lab, clinicians	CPHO, International circumpolar Surveillance committee & PHAC	Monthly		
Immunizations		Frontline health practitioners submit data to the GNWT by email or fax	DH&SS, Health Authorities, Public Health Nurses Public Health Agency Canada	Monthly Yearly	Depends on the request	The GNWT currently lacks a surveillance system that can produce timely immunization reports. In 2012, the immunization registry was established, but this is still populated by direct entry from written and

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
						excel data submissions
Notifiable diseases: Influenza		Reports from lab samples sent directly to GNWT; Sentinel sites reporting ILI through PHAC	Canadian Public Health Agency	Weekly		
Notifiable diseases: all others		iPHIS system	Public Health Agency Canada	Annual		
Notifiable diseases: Selected		ICS reporting sheets filled out based on hospitalization reports sent to GNWT by fax	International Circumpolar Surveillance	Monthly, Annual review	About one to two months, depending on how long individual is in hospital	
Diabetes Prevalence and Incidence		CIHI DAD, physician billing data, nurse submission of paper CHMIS forms	DH&SS, Health Authorities, National Diabetes	every year	Two to three years	
Cancer Incidence		Canadian Cancer Registry - NWT	DH&SS, Health Authorities	Yearly National Report	Three years	
Cancer - Incidence		CIHI DAD, pathology reports, radiology reports, autopsy reports, physician records	Canadian Cancer Registry	Yearly	Three years	
Cancer Incidence Trends		Canadian Cancer Registry - NWT	DH&SS, Health Authorities	Every 5-10 years	?	

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Cancer Screening Tests		Lab reports	Chief Medical Health Officer , Health Authorities	Quarterly	Several months to one year	
Injury Tracking		CIHI DAD, physician billing records	DH&SS, Health Authorities	Every 5-10 years		
CHMIS (Community Health Management Information System)		Community nursing staff	DH&SS, Health Authorities	Quarterly	Delayed at present. Last year available 2006	Data entry has significant backlog
FMBS: Variance Reports		FIS		Quarterly		
GNWT Report on Drinking Water	Produced jointly by HSS, MACA, ENR, and PWS. Provides detailed water quality and community water system information as well as updates on various projects and activities.	NWT Drinking Water Quality Database	Public, Cabinet, Health Canada and FPT Committee on Drinking Water	Annual	Previous year	

Division	Division Group	Contributor Name
Corporate Planning, Reporting and Evaluation		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Building on Our Foundation – A Strategic Plan for the NWT HSS System 2011-2016	The H&SS Strategic Plan for 2011-2016	Varied Review the business plan for more details. Located on I drive.	DHSS	Every 5 years	Varies	• constant changing and evolving indicators • this plan is developed in conjunction with the Department
The Northwest Territories Health and Social Services System Annual Report	The HSS Annual Report is used to: • Report on system-wide performance indicators; • Provide an update on innovative programs and initiatives in H&SS Authorities; • Satisfy a legislated requirement to report on cost of medical care plan; • Present the financial position of the Department and H&SS Authorities			Annually		
NWT Health Status Report	Profiles of the health status of NWT residents	• DAD • Vital Stats • CCHS • Tobacco Addictions • Immunization • Cancer	DHSS Public	Every 5 Years • NWT Health Status Report 2010 • NWT Health Status Report 2004		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
		• Communicable Diseases • Chronic Disease • Community Services • Census • NWT Surveys				
Performance Measures Report	Tracks indicators that are both relevant to the strategic priorities of HSS and also can provide a signal to problems that may need attention			Quarterly		
NWT Addictions Report	Profiles and provides information about the use of alcohol, tobacco, drugs, as well as gambling of NWT residents	Bureau of Statistics	Public	Every 2-3 years • NWT Addictions Report 2009 • NWT Addictions report 2006		
NWT Youth Smoking Report	Profiles the use of tobacco by NWT youth in grades 5 to 9	Bureau of Statistics	Public	Every 5 years • Youth smoking in the NWT (2009) • NWT Youth Smoking Survey (2002)		
Utilization Reports	Physician Services Report: Profiles utilization of physician services by reason (condition requiring treatment), ranked by an estimation of costs (separate??) Form part of the HSS			Every 5 years		Physicians are the second largest cost area for the H&SS system. A significant portion of physician costs go to treat patients with conditions that are preventable.

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
	accountability reporting to the Legislative Assembly and the public. These reports provide information on some of our most vital and costly services (physician services, hospital services and information on access to health centers).					
Ongoing Satisfaction Surveys	Satisfaction surveys are conducted regularly as part of the H&SS system wide evaluation and reporting system			Every 2nd year • Satisfaction with Health Care Services in the NWT • NWT Hospital Satisfaction Report – Stanton and Inuvik (2010) • Community Health Services Satisfaction Report (2009) • Hospital Satisfaction Report (2008, 2006, 2004)		
Ad Hoc reports in support of the other DH&SS divisions and Ministerial request	Example reports; Homecare, Seniors Profile, Nutrition etc.		Support other divisions as required • part of physician negotiations • special supplemental health	Ad hoc		• timing of information • reliability and consistency of the information • CFIS- to put this information into a data mart • incomplete data (missing third party claims/events)

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Health Service Reports		Community Health Data	Public Recipients	5 Years		• missing third party events • increased value with inter-jurisdictional comparable information
Issues brought forward not specifically focused to any report	1. Hospital occupancy rates in hospitals often vary by the number of open beds 2. Completeness of reports can be hindered by the lack of third party information 3. It would be to the benefit of the analysts if no show cases could show on reports 4. It is apparent that the gathering of NGO information for our data bases would be beneficial to our analysts as much of mental health is outside our reporting jurisdiction 5. Reporting of non-insured services such as the mental health clinic and mental health and community wellness workers would significantly increase the data value if it were included in the EMR scope 6. It would be extremely useful to have the true vacancy rates of Health Workers to effectively develop a human resource Community Needs Assessment 7. It will be beneficial to gain access to the CIHI Portal for comparability to other jurisdictions					

Division	Division Group	Contributor Name
Information Services		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
OCIO/IPC: capital project status reports included						
PM: YTD exp. Commitments						
FMBS: Variance Reports		FIS		Quarterly		

Division	Division Group	Contributor Name
Health Services Administration		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Fiscal Accountability/ Program Management			Finance Division	Monthly/quarterly		
Vital Statistics		Photocopies of Registration Forms	Stats Canada Population Health Elections Canada Elections NWT Government of Nunavut Aboriginal Affairs and Northern Development Canada Human Resource Canada	Monthly		Legislated
Variance Reports		SAM	Finance Division	Quarterly		
Migration Reports		HMIS	Provinces/Territories	Monthly		
Health Care Card Issuance		HMIS	Contractor	Weekly		

Division	Division Group	Contributor Name
Medical Travel Services (Stanton)		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Utilization reporting	Comparison of utilization information for similar periods over different years			Annual		
Travel costs by Community				Annual		
Travel costs by type of service	Extensively used for evaluation of services considered to be brought into NWT – comparing to current costs and travel requests (e.g.: reviewing the need for a new CT scanner)			Ad hoc – legislative requests		
Variance Reports		FIS	Finance/FMBS	Quarterly		

Division	Division Group	Contributor Name
Community Wellness and Social Services		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
Report of the Director, Child and Family Services	This report is a legislated requirement	Child and Family Services Information System	Legislative Assembly	Annual	Up to 18 years	CFIS no longer supported by the Vendor and must be replaced
NORTH Report	Forms part of the Health Portfolio Contribution Agreement with Health Canada	FNIHB contribution funding recipients	First Nations and Inuit Health Branch, Health Canada	Annual	Up to 5 years	Recipient capacity to collect and submit the required information
Status Reports – Mental Health and Addictions action plan		Program records	Minister	Sessional and as requested	Up to 3 years	
Status Reports – Implementation of Rxs from the Standing Committee Review of the C&FS Act		Program records	Minister	Sessional and as requested	Up to 3 years	
Early Childhood Development Report	Should be in Child and Family Services			2/3 Years		

Division	Division Group	Contributor Name
Territorial Health Services	Territorial Health Services	Donna Allen

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
N/A	Information requests come from different health authorities, Nursing associations, the Maternal Prenatal Committee etc			Ad hoc		
Home Care status report	Report based on program obligations from Federal and NWT requirements	Community Health Management Information System/Authority Narrative Reports	Federal Government	Annual		
Southern placement report	Indicating associated expenditures by southern facility	Through variance reporting process	Deputy Minister	Quarterly		
Southern placement usage requests.	Receiving multiple requests regarding southern program level information covering the combination of both placement facility information and associated travel costs	Coordinator, Southern Placements - Finance		Ad hoc		
Facilities utilization information		CIHI Data	DH&SS – Senior Management	Monthly		
TeleHealth Activity Report	Activity report over a time period		Deputy Minister/ Legislative Assembly	Annual		
Home Care	Essential for funding	Health Suite	Federal Government	Semi-Annual		Defined by Federal and NT Health Care Group
Telecare		Clinadata	DM	Quarterly		

Reporting Obligations	Notes	Data Sources	Recipient	Frequency	Age of Data	Issues
		Contract service provider	Regional Advisory Committee	Monthly		
FMBS: Variance Reports		FIS		Quarterly		

Appendix B: HSSA Reporting

Background

MNP has been contracted by the NWT Department of Health and Social Services to assist with:

- The development of an inventory of existing performance monitoring and reporting within the system, and working with primary stakeholders to identify system-wide performance and reporting requirements; and
- The development of an overall accountability framework that outlines performance reporting requirements for key target audiences, including timing, indicators, and data collection responsibilities, and creation of an action plan to implement the accountability framework and performance measurement system.

Your help is needed to determine the information collected on a regular basis to inform overall performance, decision making and the reporting obligations of the Health and Social Services Authorities (HSSA) in the NWT.

In Section 1.1 below, please list and describe:

- What information **you regularly collect** and feel is critical to managing performance and informing decision making for your HSSA.
- What information **you believe should be collected, but is not**, and is critical to managing performance and informing decision making for your HSSA.

In Section 1.2 below, please provide a listing of all of the reports that you are obligated to provide to:

- Territorial and/or Federal Government Departments/ Agencies; and
- All other recipients including other organizations, agencies, or the public.

For each report that you are obligated to provide, indicate the following:

- **Name:** The name of each report that you produce/receive.
- **Description & Purpose:** A brief description of the report and its purpose including the intended audience and how it is being used (management decision making, accreditation process, etc.)?
- **Performance Indicators:** If there is performance indicators included in the report please specify what they are?
- **Frequency:** How often the report needs to be provided (monthly, annually, etc)
- **Data Source:** Identify the source used to contribute the required information, if the data is collected manually or electronically and if the method of data collection can be modified to provide multiple uses.
- **Age of Data:** How old is the data that is being used to produce the report?
- **Roll Up for Territorial Level Reporting:** Is the data collected in a format that allows it to be rolled up with other HSSA data for Territorial level reporting?

- **Issues:** Issues affecting the generation of the report. What makes it difficult to produce the report? Is the data readily available?

In Section 1.3 below please identify those questions that you are being asked by your Board members and/or community members that you are unable to answer because you do not have the data or information. Please be specific

An MNP representative will be following up with each of you by telephone to discuss further.

Critical Information for Managing Performance

The following information is critical for managing performance and informing decision making for your HSSA.

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
MEDICAL TRAVEL	
Medical travel trip statistics	High level stats such as reasons for medical travel based on acuity.
Financial statistics	The MT system tracks per patient trip, not necessarily vendor trips. i.e. for one charter trip you may have 6 different patients. While we may be aware 6 people travelled we are not aware they were all on one flight. The same would be true for ground transport. We track this manually through excel for medevacs
Medevac spreadsheet – crucial so the medical director can follow up on instances of inappropriate medevacs and create report for all Authorities so they are aware of problems.	Need better information to manage contracts and performance against requirements. Was patient outcome improved?
	Proper approvals for all instances of medical travel. Proper approvals for all escorts
PHARMACY	
Inventory	Pharmacist Workload – To measure clinical impact on patient care. Collect data to justify future increase in FTEs.
Night Cupboard Usage	
Narcotic Discrepancy Reports	
Daily Controlled Med Report	
Month End Billing	
Medications not Loaded	
Outdated Narcotics	
Loading and Unloading (Narcotics)	
Refill Pick and Delivery	
Weekend Narc Refill	
Weekend Narc Load	
Nicotine Usage Report	

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
Do Not Use Abbreviations Indicator Report	
Vaccines Purchased	
BIOMED	
Preventative Maintenance Completion Rate – High Risk	
Preventative Maintenance Completion Rate – Non-High Risk	
DIAGNOSTIC IMAGING	
Wait Times	
Quantifying DI Exams	
Utilization of Units, Transfusion	
No Shows	
Turnaround times	
LIST OF REHABILITATION SERVICES INDICATORS **Volume/Quantitative indicators** MONTHLY REPORTS: • Waiting times • No show rate • Inpatient attendances – ○ Nunavut vs. NWT ○ Adult vs. peds • Outpatient attendances ○ Nunavut vs. NWT ○ Adult vs. peds ▪ Preschool vs. school age ○ Yellowknife vs. Other NWT vs. Kitikmeot (by community) ○ Telehealth attendances ○ Homecare, TDF, Avens • Workload Measurement ○ Direct patient care time ○ Indirect patient care time ○ Non-patient care time	Monitor program delivery and impact on client outcomes.

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
• Track in-services given and attended. **Following each Travel Clinic:** • attendances by community ○ Adult vs. peds • # of service days to each community (includes travel time) • Amount of time spent delivering community service in YK i.e. prep and reports • Amount of overtime accrued during travel. • Actual cost of travel service – transportation, accommodation + per diem. ANNUAL REPORTS: <u>Program specific – Outpatients</u> • # of referrals received ○ urgent vs. routine • # of WCB referrals • # of new patients • # of carry over attendances <u>Program specific– SLP School – indicators for each school</u> • # students referred • # screened/assessed • # requiring follow-up • # discharged • # seen for language • # seen for articulation/phonology • # seen for voice • # seen for fluency • # seen for augmentative <u>Program specific – OT School – indicators for each school</u> • # students referred • # screened/assessed • # requiring follow-up	

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
• # discharged Program specific – Infant Hearing Program (also reported to QM committee) • # of infants screened ○ # screened in Stage 1 – Nursery ○ # screened in Stage 2 – Audio clinic ○ # assessed in Stage 3 – full Audio assessment • # of infants passed • # of infants referred • # of infants identified with hearing loss • # of infants identified with risk factors Clinical Outcomes/Qualitative indicators: (all clinical outcomes reported to QM committee) Physiotherapy - Outpatients • Lower Extremity Functional Scale (LEFS) • Upper Extremity Functional Scale (UEFS) • Neck Disability Index (NDI) • Oswestry Low Back Pain Disability Occupational Therapy • Functional Independence Measure – Homecare • Goal Attainment Scaling – Preschool • Peabody Developmental Motor Scale – Aboriginal Head Start + Four Plus • Satisfaction Questionnaire – Travel + CDT Speech Language Pathology • Goal Attainment Scaling – Aboriginal Head Start, Four Plus + Schools	
Hospital Wide	
Security Patient Watches	To determine cost effectiveness of current model of service delivery
Patient Watch Uses	As above

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
ER Triage Wait Times	CTAS requirement
ER Left Without Being Seen/Against Medical Advise	High risk issue
Medication Reconciliation Upon Admission	Required Organizational Practice as per Accreditation Standards (ROP)
Mandatory Certifications	
Falls Risk Assessment Upon Admission	ROP
Client Satisfaction	Standard of Care
Surgical Site Infections	ROP
Hospital Acquired MRSA Infections	ROP
Hospital Acquired VRE Infections	ROP
Hospital Acquired C. difficile Infections	ROP
Hospital Acquired Urinary Tract Infections	Identified as above CIHI benchmark
Maternal/Child Services (Pediatrics/OBS)	
VBAC Rate	All are standards of care
Workplace Hazards	
Breastfeeding Initiation Rates	
Cesarean Section Rates	
Induction of Labour Rates	
Rates of Trauma to the Perineum	
Psychiatry	
Patient Satisfaction Survey	
Suicide Risk Assessment	ROP
30 Day Readmission Rate	
Average Length of Stay	
Workplace Hazards	
Official Languages	
French Language Services	
Aboriginal Wellness Services	
Medicine	

Currently Collected – Describe the critical information for managing performance and informing decision making	Not Collected – Describe the critical information for managing performance and informing decision making
Patient Satisfaction	
Pressure Ulcers	ROP
Registration	
Declaration Audit sheet	
HMIS Extract	
Daily Census Summary	
Extended Care Unit	
Average of Pressure Ulcers	ROP
Workplace Hazards	
Surgical Services	
Surgical Checklist	ROP
OR No Shows	Measure effective utilization
Health Records	
Incomplete Charts	
Missing Discharge Summaries	
Staff Development & Education	
SafeStart Attendance	
Orientation to Hospital Attendance	
Nursing Orientation Attendance	
CPR, NCI, IV & Cardiac Rhyth	
Certification Exams	
Journal Usage	
	Medipatient does not retain the "date of referral" information once an appointment is booked, therefore making it difficult to track wait time from the date of referral.